Supreme Court, U. S.
FILED
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1973

No. 73-1994

JULIAN VELLA,

Petitioner,

vs.

FORD MOTOR COMPANY,

Respondent.

APPENDIX

THE INLAND PRESS, DETROIT, MICHIGAN

PET. FILED 7-8-74

CERT. GRANTED 10-21 74

JOINT APPENDIX

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RELEVANT DOCKET ENTRIES

1970		
Feb.	6	Complaint and demand for jury, filed. Summons issued.
Mar.	6	Answer of Ford Motor Company, filed.
1972		
Apr.	11	Jury trial begins—adj. to Apr. 12/72.
May	5	Jury trial resumed: verdict of no cause of action as to Court 1 & 2—as to Court 3 accident was due to sole negligence of ptf., ptf. awarded maintenance and cure for the period of June 29/68 to June 29/70. Jury polled and discharged.
May	5	Order of judgment of no cause of action as to Count 1 & 2 and for award of $5,848.00 as to Count 3 for maintenance and cure without interests and costs, filed and entered. Notices mailed.
May	26	Notice of appeal, filed (plaintiff).
Aug.	14	Notice of appeal, filed (defendant).
1974		
May	7	Judgment on mandate modifying judgment of District Court, filed, entered.

COMPLAINT

(Filed February 6, 1970)

NOW COMES plaintiff by and through his counsel undersigned, the Law Offices of Leonard C. Jaques, and in declaring against the above named defendant on information and belief, states as follows:

FOR FIRST CAUSE OF ACTION

First. At all times material to issues herein, defendant was and still is a corporation existing under and by virtue of laws of the State of Michigan

Second. At all times material hereto, defendant owned or operated, managed, controlled or otherwise maintained a certain merchant vessel known as the SS McNAMARA, a vessel of more than twenty tons burden, which vessel was engaged at all times material hereto to maritime commerce on navigable waters of the United States and particularly the Great Lakes and tributaries thereof, including waters within this jurisdiction.

Third. On or about the fourth day of April, 1968, plaintiff was in the employ of defendant and assigned by the defendant to the service of the SS McNamara and was a member under articles of that vessel's crew in the engine department under classification of "oiler," a petty officer of the ship's crew, earning monthly wages at the rate of Four Hundred Fifty ($450.00) Dollars in addition to overtime pay, board, lodging, welfare benefits accruing daily to his credit and other rewards.

Fourth. Plaintiff as a seaman now brings this action pursuant to the provisions of the Merchant Marine Act of 1920, under 46 United States Code, §688 et seq, which act is popularly known as the Jones Act.

Fifth. On or about the fourth day of April, 1968, when the vessel aforesaid was at sea, plaintiff in the course of his employment and in exercising all due care and caution, suffered injury to his person arising from an incident created by the negligence and carelessness of the defendant, its servants, agents and employees and by reason of unseaworthiness of the aforesaid vessel and without plaintiff contributing to the cause of his injury in any way whatsoever.

Sixth. At the time of the incident complained of in this cause, plaintiff was peremptorily assigned to the duty of replacing and securing a floor plate in the lower engine room deck.

Seventh. Plaintiff was required to perform the aforementioned task under adverse conditions and without proper assistance in the undertaking.

Eighth. As plaintiff maneuvered about the area where the floor plate was being replaced, and in contorting his body in a manner required to perform the difficult task, plaintiff lost his balance, slipped on the oily floor plate and struck his head on an electrical box as he fell to the plates.

Ninth. The trauma to plaintiff's head caused by the fall created a stunning sensation experienced by plaintiff with devastating symptoms of damaging nature and grave consequences to follow thereafter as a result of the trauma.

Tenth. Plaintiff attempted to carry on with his work assignment as an oiler in the engine department of said vessel until he formally made a report of said accident to the third assistant engineer, Clifford J. Hagan, on the sixth day of June, 1968, at which date the condition of plaintiff had deteriorated to the point where attention of professional medical nature was required.

Eleventh. At all times material hereto, defendant owed to plaintiff the following duties:

(a) To provide plaintiff with a safe place to work.

(b) To properly inspect and detail the area of which plaintiff was peremptorily ordered to work.

(c) To equip the vessel with safe and seaworthy gear and equipment and to maintain the same in a seaworthy condition and a reasonably safe state of repair.

(d) To provide that repairs to gear in dangerous places be accomplished under proper circumstances and under proper supervision and in a reasonably safe manner.

(e) To reasonably insure that all danger to footing was properly removed from the area about which plaintiff was assigned to work.

(f) To have provided sufficient rigging for the replacement of the heavy floor plate.

(g) To have insured sufficient personnel in number and in work quality to perform that task to which plaintiff was assigned.

(h) To properly supervise and direct plaintiff in the work assigned aforesaid.

(i) To have assured accompanying hands of the engine

department to be with and about plaintiff's work area during all times when such dangerous activity was being performed.

(j) To warn and apprise plaintiff of his peril.

(k) To maintain proper lookout for plaintiff's life and limb.

(l) To have equipped the vessel with bulkheads without protrusions of dangerous quality with the type of instrumentality as that upon which plaintiff struck his head.

(m) To have placed the electrical box in a place on the vessel which would not have interfered with the work performance of plaintiff aforesaid.

Twelfth. Notwithstanding said duties owed by defendant to plaintiff, and in contravention thereof, defendant committed the following acts and omissions constituting negligence.

(a) Failure to provide plaintiff with a safe place to work.

(b) Failure to properly inspect and detail the area to which plaintiff was peremptorily ordered to work.

(c) Failure to equip the vessel with safe and seaworthy gear and equipment and to maintain the same in a seaworthy condition and a reasonably safe state of repair.

(d) Failure to provide that repairs to gear in dangerous places be accomplished under proper supervision and in a reasonably safe manner.

(e) Failure to reasonably insure that all danger to footing was properly removed from the area about which plaintiff was assigned to work.

(f) Failure to have provided sufficient rigging for the replacement of the heavy floor plate.

(g) Failure to have insured sufficient personnel in number and in work quality to perform that task to which plaintiff was assigned.

(h) Failure to properly supervise and direct plaintiff in the work assigned aforesaid.

(i) Failure to have assured accompanying hands of the engine department to be with and about plaintiff's work area during all times when such dangerous activity was being performed.

(j) Failure to warn and apprise plaintiff of his peril.

(k) Failure to maintain proper lookout for plaintiff's life and limb.

(l) Failure to have equipped the vessel with bulkheads without protrusions of dangerous quality with the type of instrumentality as that upon which plaintiff struck his head.

(m) Failure to have placed the electrical box in a place on the vessel which would not have interfered with the work performance of plaintiff aforesaid.

Thirteenth. As a direct and proximate result of the negligence and carelessness of defendant as aforestated, plaintiff sustained the following injuries and damages, inter alia:

(a) Pain and suffering.

(b) Multiple contusions, abrasions and traumatic injuries throughout the body.

(c) Contusion to the cerebral hemisphere.

(d) Shock to his central nervous system and the sequaelae thereof.

(e) Medical expenses, past and future.

(f) Loss of earnings and earning capacity.

(g) Mortification and humiliation.

(h) Future pain and suffering.

FOR A SECOND CAUSE OF ACTION

Fourteenth. Plaintiff realleges and incorporates by reference each and every allegation set forth and contained in the first cause of action and in articles first through thirteenth of this Complaint with the same force and effect as though pleaded herein in full, and further alleges:

Fifteenth. Plaintiff elects to maintain a cause of action under the General Admiralty and Maritime Law and further takes benefit of all statutes of the United States modifying or extending the common law right or remedy in cases of personal injury.

Sixteenth. Defendant failed to furnish and provide plaintiff with a seaworthy vessel at the aforementioned time and place material to issues herein.

FOR A THIRD CAUSE OF ACTION

Seventeenth. Plaintiff realleges and incorporates by reference each and every allegation set forth in the first cause of action and the second cause of action of this complaint with the same force and effect as though pleaded herein in full, omitting all allegations of negligence, unseaworthiness, pain, suffering, loss and earnings and earning capacity and any and all claims other than amounts needed to maintain and cure himself since the time of sustaining said injuries and until such time as the maximum

medical treatment has been rendered and for a reasonable time thereafter, and further alleges:

Eighteenth. In accordance with the laws of admiralty in cases so made and provided, defendant at all times material to issues herein owed and still does owe to plaintiff a duty to provide him with maintenance and cure.

Nineteenth. Plaintiff has spent amounts in excess of One Hundred ($100.00) Dollars to maintain and cure himself and will continue in the future to spend large amounts for his maintenance and cure necessitated by the aforestated injuries.

WHEREFORE, plaintiff demands trial by jury and judgment against defendant in the amount of Three Hundred Thousand ($300,000.00) Dollars together with costs and reasonable attorney fees; and

Plaintiff further prays to be able to prosecute this action without advancement of, or give security for, costs to the United States of America and under favor thereof until the disposition of this cause has occurred as provided in such cases applicable hereto, and particularly in accordance with the provisions of Title 46, United States Code §688 et seq.

LAW OFFICES OF
LEONARD C. JAQUES
Attorney for Plaintiff
1325 Penobscot Building
Detroit, Michigan 48226
Telephone: 961-1080
By: /s/ LEONARD C. JAQUES

Dated: February 5, 1970

JURY DEMAND

NOW COMES plaintiff by and through his counsel undersigned, the Law Offices of Leonard C. Jaques, and hereby demands that the above entitled cause be tried before a jury.

LAW OFFICES OF
LEONARD C. JAQUES
Attorney for Plaintiff
1325 Penobscot Building
Detroit, Michigan 48226
By: /s/ LEONARD C. JAQUES

Dated: February 5, 1970

ANSWER

(Filed March —, 1970)

NOW COMES the defendant, Ford Motor Company a Delaware corporation, by its attorneys Foster, Meadows & Pollard, and in answer to plaintiff's complaint says:

FIRST CAUSE OF ACTION

First: Defendant denies the allegations of paragraph First and affirmatively alleges it is a corporation organized and existing under the laws of the State of Delaware with its principal place of business located in Dearborn, Michigan.

Second: Defendant admits the allegations of paragraph Second.

Third: Defendant admits the allegations of paragraph Third.

Fourth: Defendant admits the allegations of paragraph Fourth.

Fifth: Defendant denies the allegations of paragraph Fifth.

Sixth: For lack of information and belief defendant neither admits nor denies the allegations of paragraph Sixth and leaves plaintiff to his proof thereof.

Seventh: For lack of information and belief defendant neither admits nor denies the allegations of paragraph Seventh and leaves plaintiff to his proof thereof.

Eighth: For lack of information and belief defendant neither admits nor denies the allegations of paragraph Eighth and leaves plaintiff to his proof thereof.

Ninth: For lack of information and belief defendant neither admits nor denies the allegations of paragraph Ninth and leaves plaintiff to his proof thereof.

Tenth: Defendant admits that on June 29, 1968 plaintiff reported an accident to Clifford J. Hagan, Third Assistant Engineer. For lack of information and belief defendant neither admits nor denies the remaining allegations of paragraph Tenth and leaves plaintiff to his proof thereof.

Eleventh: Defendant denies the allegations of paragraph Eleventh.

Twelfth: Defendant denies the allegations of paragraph Twelfth.

Thirteenth: Defendant denies the allegations of paragraph Thirteenth.

SECOND CAUSE OF ACTION

Fourteenth: Defendant repeats and realleges each and all of its answers contained in paragraphs First through Thirteenth of its Answer to the First Cause of Action of the Complaint with like effect as if herein repeated.

Fifteenth: Defendant has no answer to make as to plaintiff's elections and the matters of law alleged in paragraph Fifteenth.

Sixteenth: Defendant denies the allegations of paragraph Sixteenth.

THIRD CAUSE OF ACTION

Seventeenth: Defendant repeats and realleges each and all of its answers contained in paragraph First through Fifteenth of its Answer to the First and Second Cause of Action of the Complaint with like effect as if herein repeated.

Eighteenth: Defendant denies the allegations of said paragraph Eighteenth.

Nineteenth: For lack of information and belief defendant neither admits nor denies the allegations of paragraph Nineteenth and leaves plaintiff to his proof thereof.

FOR A SECOND SEPARATE AND COMPLETE AFFIRMATIVE DEFENSE TO ALL OF THE ALLEGATIONS OF ALL OF THE CAUSES OF ACTION OF SAID COMPLAINT, DEFENDANT SAYS:

Twentieth: That any accident or injury the plaintiff may have sustained while in the employ of defendant was caused solely as the result of plaintiff's own negligence, carelessness, inattention to duty and lack of ordinary prudence and care.

FOR A THIRD SEPARATE, DISTINCT AND PARTIAL DEFENSE TO ALL OF THE ALLEGATIONS OF ALL OF THE CAUSES OF ACTION OF SAID COMPLAINT, DEFENDANT SAYS:

Twenty First: That any accident or injury the plaintiff may have sustained while in the employ of defendant was caused or contributed to by his own negligence, carelessness, inattention and lack of ordinary prudence and care.

WHEREFORE defendant demands judgment in its favor dismissing the complaint with costs.

FOSTER, MEADOWS & BALLARD
By /s/ John A Mundell, Jr.
3266 Penobscot Building
Detroit, Michigan 48226
961-3234
Attorney for Defendant

Dated: March —, 1970

Verdict

Detroit, Michigan
Friday, May 5, 1972

APPEARANCES:

PHILIP MEYER, Esq.
Appearing on behalf of Plaintiff.
RAYMOND BALLARD, Esq.
Appearing on behalf of Defendant.

PROCEEDINGS

11:40 a.m.

(Jury not present)

THE COURT: Gentlemen, I have a message from the jury that they have reached a verdict.

Mr. McCrary, will you bring the jury in, please?

BAILIFF McCRARY: Yes, sir:

(Jury enters courtroom)

THE COURT: Mr. Foreman, I understand that the jury has reached a verdict?

FOREMAN HOLT: Yes, sir.

THE COURT: Mr. Duffy, will you please take the verdict?

CLERK DUFFY: Members of the jury, have you agreed upon a verdict?

FOREMAN HOLT: Yes.

CLERK DUFFY: How do you find as to the first and second causes?

FOREMAN HOLT: On the first and second clauses, no cause for aetion.

CLERK DUFFY: No cause for action. As to the third cause of action, how do you find?

FOREMAN HOLT: I would like to read that off. It's on a slip of paper.

On Count number three, we find for the plaintiff. And we further find that the accident was due to the sole negligence of the plaintiff, Julian Vella. We award him maintenance and cure at $8.00 per day for the period of June 29, 1968 to June 29, 1970.

CLERY DUFFY: Members of the jury, harken to your verdict as the Court will record it. You say you find a verdict as to the first and second causes in favor of the defendant of no cause for action. As to the third cause of action, you find for the plaintiff. You find the accident was due to the sole acts of the plaintiff. You find maintenance and cure in the amount of $8.00 per day for a period beginning June 29, 1968 to June 29, 1970. And so say you all?

FOREMAN HOLT: That's right.

A JUROR: Did you say sole negligence? That was our verdict.

CLERK DUFFY: That it was due to the sole negligence of the plaintiff.

FOREMAN HOLT: That's right.

(Whereupon an affirmative response was recorded for each and every jury by the Court reporter)

MR. MEYER: Your Honor, plaintiff would request that the jury be polled.

THE COURT: All right.

CLERK DUFFY: Juror number one, Charles Holt, was that and is that your verdict?

FOREMAN HOLT: Yes, sir, it is.

CLERK DUFFY: Juror number two, Esther H. Fine, was that and is that your verdict?

JUROR FINE: Yes.

CLERK DUFFY: Juror number three, John R. Arnold, was that and is that your verdict?

JUROR ARNOLD: Yes, sir.

CLERY DUFFY: Juror number four, Jean A. Christie, was that and is that your verdict?

JUROR CHRISTIE: Yes, sir.

CLERK DUFFY: Juror number five, Dorthene Mitchell, was that and is that your verdict?

JUROR MITCHELL: Yes.

CLERK DUFFY: Juror number six, Virgil J. Bracewell, was that and is that your verdict?

JUROR BRACEWELL: Yes, sir.

CLERK DUFFY: Juror number seven, Polly Anne Bradley, was that and is that your verdict?

JUROR BRADLEY: Yes, it is.

CLERK DUFFY: Juror number eight, Jean H. Bankey, was that and is that your verdict?

JUROR BANKEY: Yes, sir.

CLERK DUFFY: Juror number nine, Lorena M. Schutzler, was that and is that your verdict?

JUROR SCHUTZLER: Yes, sir.

CLERK DUFFY: Juror number ten, Herbert R. Neal, was that and is that your verdict?

JUROR NEAL: Yes, sir.

CLERK DUFFY: Juror number eleven, Jerome Celmer, was that and is that your verdict?

JUROR CELMER: Yes, sir.

CLERK DUFFY: Juror number twelve, Irene Martella, was that and is that your verdict?

JUROR MARTELLA: Yes, sir.

MR. MEYER: Your Honor, may counsel approach the bench for a moment?

THE COURT: All right.

(Whereupon an off the record discussion was had at the bench between the Court and counsel)

THE COURT: Ladies and gentlemen of the jury, let me say that the attorneys have already expressed their thanks to you; and if there is any way I could add to that thanks, I certainly would and do mean to because this was a long trial and difficult in many respects, not only with the law involved and the facts but because it took so much longer than had been anticipated by the attorneys and therefore the Court was caught in so many other things. And the fact that all of you showed up and showed the attention that you did and the time you took in reaching your verdict would be an indication of the interest and dedication of all of you and I really want you to know that I'm grateful.

I might explain to you that of the days we took off, there was only one day that was really for personal business and it has to do with my daughter who is away at college. There was a father's weekend and I long ago said that would take priority over anything else in my life and that's about the only thing that could have kept me from being here for a trial. And so I'm appreciative of your interest here and going with us on everything we did.

It has been a real pleasure having you here and I hope to have the good fortune in the future to work with you again. Thank you all very, very much. You are all excused. Will you report to Miss Burge in Room 214 for further assignment. You are excused.

(Jury discharged)

THE COURT: The Court has before it the various motions for a directed verdict on the part of the plaintiff and motions for dismissal on the part of the defendant that

were made throughout the course of the trial. The Court kept these motions under advisement and the Court will now decide them by denying all of these motions.

All right, we will be in recess.

• • •

ORDER OF JUDGMENT

At a session of said court held Detroit, Michigan this 5th day of May, 1972.

Present: Hon. Lawrence Gubow
U.S. District Judge

The above entitled cause having been tried before the Court and jury alleging three causes of action, namely: negligence under the Jones Act, unseaworthiness of the vessel and maintenance and cure benefits inuring to plaintiff, and the jury having returned a verdict in favor of the defendant of no cause for action as to the first two causes of action and awarding the plaintiff maintenance and cure at eight dollars [$8.00] per day for the period of June 29, 1968 to June 29, 1970.

NOW, IT IS ORDERED that the plaintiff fail and take naught against the defendant as to the causes of action of negligence under the Jones Act and unseaworthiness of the vessel and,

IT IS FURTHER ORDERED that the plaintiff be and is hereby awarded eight dollars [$8.00] per day for a period of June 29, 1968 to June 29, 1970 under the maintenance and cure action, 731 days for a total of $5,848.00 without interest and costs.

/s/ LAWRENCE GUBOW
U.S. District Judge

[TRANSCRIPT OF DISTRICT COURT'S DECISION ON MOTION FOR JUDGMENT NON OBSTANTE VERDICTO DATED JULY 17, 1972]

The Court has before it really two motions. The first one is a motion for a judgment not withstanding the verdict in favor of the plaintiff concerning Plaintiff's claim for maintenance and cure. In this case, the plaintiff was employed as a seaman on the S.S. Robert McNamara until his discharge on June 28, 1968. During the course of the preparation of his discharge papers, he claimed to have been injured in a fall on April 4, 1968, and it is these alleged injuries which eventually led to the plaintiff's action against the defendant that we are concerned with here.

The plaintiff's action was in three counts: One, for negligence under the Jones Act; two, for unseaworthiness under the general maritime law; and three, for maintenance and cure. Following a lengthy trial, the jury returned a verdict of no cause for action as to the first two counts but awarded Plaintiff eight dollars a day from June 29, 1968 to June 29, 1970 for maintenance and cure. And the defendant has now made this timely motion for judgment n.o.v.

In this regard, the defendant takes two positions. First, he argues that the plaintiff offered no proof that his injury was caused while in service of the ship and that he failed to bring himself within the scope of maintenance and cure. Second, the defendant maintains that the plaintiff failed to prove he suffered from a curable disability for which he obtained curative rather than palliative treatment, and that since maintenance and cure applies only for curative treatment, the plaintiff should not have recovered.

Now, a motion for judgment notwithstanding the verdict may only be granted when, without weighing the credibility of the evidence, there can be but one reasonable conclusion as to the proper judgment. *Rithe* versus *Saginaw*, 337 Fed 2nd 393. Here the defendant would have the Court conclude, without weighing the evidence, that the only reasonable conclusion from the evidence presented is that Plaintiff did not suffer an injury while in the service of the ship. However, there was evidence presented to the jury that some time after the fall the plaintiff suffered dizziness which was eventually diagnosed as a vestibular labyrinthine disorder. To infer from this that the fall caused the disorder is not unreasonable. Well, the Court may not have decided the same way from the facts presented, but the jury did. The fact that physical examinations immediately subsequent to the alleged fall did not detect the disorder is not conclusive of the issue since those examinations did not include certain tests which a disorder of the sort allegedly suffered here could be detected with.

For the second point, that Plaintiff's treatment was not curative but palliative in nature and therefore not within the scope of maintenance and cure, the defendant points to the testimony of Dr. Heil, the ear specialist, who testifies that there is no known cure for the vestibular deficit suffered by Plaintiff. While it is true that maintenance and cure is not available for a sickness declared to be permanent, it is also true that maintenance and cure continues until such time as the incapacity is declared to be permanent. *Narzian* v. *Nicholson Transit Company*, 174 Fed Supp 348, an Eastern District of Michigan case decided by Judge Thornton. Let me read from that case on page 349:

> "The rule to be applied in limiting the maintenance and cure recovery is laid down in *Farrell* v. *United States*, 336 US 511. The Court there quotes from a draft convention submitted in 1936 by the General Conference of the International Labor Organization in Geneva, subsequently ratified by the Senate and proclaimed by the President effective for the United States on October 29, 1939. The provision quoted in the *Farrell* case states that maintenance and cure continues until the seaman is cured or until 'the sickness or incapacity has been declared of a permanent character.' The Court cites approvingly in this connection."

And then cases are cited.

> "At most, recovery should not be extended beyond the time when the maximum degree of improvement of his health is reached. We can find no authority approving a longer period of recovery. Recovery of maintenance and cure should not extend beyond the time when a maximum degree of improvement in the health of an injured seaman has been reached."

Then on page 350:

> "We think that the only proper interpretation of the rule is that once the administration of curative treatment has ceased because medical science can do no more for the patient to improve his condition, then the seaman's right to maintenance and cure ceases."

Now, the Court agrees with the principal (sic) spelled out by Judge Thornton in this case. In our case, the only physician competent to testify as to the permanence of the plaintiff's incapacity was Dr. Heil, the ear specialist. Dr.

Heil did not even examine the plaintiff until March 20, 1972. However, the jury did not grant maintenance and cure past June 29, 1970, almost two years before the declaration that the condition was permanent. Thus, the jury found that for the period for which a judgment was granted, the plaintiff was entitled to maintenance and cure.

Now, as I said earlier, a motion for judgment n.o.v. may only be granted when, without weighing the credibility of the evidence, there can be but one reasonable conclusion as to the proper judgment. In the opinion of the Court, it just cannot be said that from the facts, from the testimony without weighing the credibility of the evidence, there could be but one reasonable conclusion. For this reason, I'm going to deny the motion for judgment n.o.v.

With regard to the other motion filed by the plaintiff under Rule 60(B) for relief from judgment on the grounds that the Court had been in error when it did not award Plaintiff interest on the judgment for maintenance and cure and counsel fees, on the issue of interest, the defendant argues that the plaintiff did not ask for prejudgment interest in his complaint. Defendant further argues that since Plaintiff elected to bring the action on the civil side rather than in admiralty, the plaintiff is bound by the rule that in federal cases where jurisdiction is based upon federal law rather than upon diversity, interest on a personal injury claim runs from the date of entry of judgment rather than from the date of judicial demand, citing the case of *Divernay* v. *Alcoa Steamship Company,* 217 Fed Supp 698 at page 700. While this issue arises out of a claim for maintenance and cure rather than personal injury, the same reasoning used by the Divernay Court would apply here. There the Court said and I quote:

> "In the instant case, which was predicated upon a federal statute, the Jones Act and upon maritime law, it is the opinion of this Court that Title 28, U.S. Code, Section 1961 is controlling in that interest runs only from the date of entry of judgment."

Our case also is founded on federal maritime law and was brought on the civil side. However, even if Title 28, Section 1961 does not apply to the claims for maintenance and cure, the plaintiff would not prevail. In *Rouald* v. *Cargo Carriers, Inc.*, 243 Fed Supp 629, the Court said at page 633:

> "The award of interest and attorney's fees is discretionary with the Court. That being the case, Plaintiff is incorrect in alleging, as he does, that he is entitled to prejudgment interest as a matter of law."

It follows that the Court was not in error when it declined to award interest on this judgment. Thus, Plaintiff's reliance on Rule 60(B) for relief from judgment on the grounds of mistake is ill founded. The same applies with regard to Plaintiff's contention that the Court was in error as a matter of law in not awarding attorney's fees. This, like the awarding of interest, is a matter for the Court's discretion. *Rouald* v. *Cargo Carriers, Inc.*, 243 Fed Supp 629.

The plaintiff has cited to the Court the case of *Jordan* v. *Norfolk Dredging Company,* 223 Fed Supp 79, which construes *Vaughn* v. *Adkinson,* 369 US 527, on the question of whether award of attorney's fees to a plaintiff in a maintenance and cure claim was dependent on a showing of callous behavior on the part of a shipowner in with-

holding maintenance and cure. The Jordan Court concluded that under *Vaughn*, payment of attorney's fees was proper regardless of callousness of the ship owner. Defendant, on the other hand, has cited to the Court cases which reach exactly the opposite conclusion about *Vaughn* and hold that ship owners callousness isn't a necessary prerequisite for the recovery of attorney's fees. *Robertson* v. *S.S. American Builder*, 285 Fed Supp 794, 1967; *Roberts* v. *S.S. Argentina*, 1964 A.M.C. 1696.

It is clear, as the Court in *Robertson* v. *S.S. American Builder* explicitly noted, that the courts have not arrived at a consistent rule with this regard. In view of this inconsistency, the Court here feels that the presence or absence of callousness is a useful factor to help the Court in the exercise of the discretion is has to award or withhold attorney fees.

In our case, it is not disputed that the ship owner withheld maintenance and cure in good faith belief, based upon physical examinations of the plaintiff following his fall, that the plaintiff was fit for duty. Since there is no evidence of callousness on the part of the defendant, attorney fees will not be awarded. For these reasons, Plaintiff's motion for interest and attorney fees is denied as well.

UNITED STATE DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

JULIAN VELLA,
Plaintiff-Appellant,
vs.
FORD MOTOR COMPANY,
Defendant-Appellee.

May 26, 1972
No. 34422

NOTICE OF APPEAL

Appeal is hereby requested from the Order of Judgment as to the first cause of action pertaining to negligence under the Jones Act and the second cause of action pertaining to unseaworthiness under the General Maritime Law of no cause for action entered May 5, 1972.

LAW OFFICES OF LEONARD C. JAQUES
By /s/ LEONARD C. JAQUES
Attorneys for Plaintiff-Appellant
1325 Penobscot Building
Detroit, Michigan 48226
(313) 961-1080

DATED: May 26, 1972

NOTICE OF APPEAL

(Filed August 14, 1972)

NOTICE IS HEREBY GIVEN that Ford Motor Company, defendant above named, hereby appeals to the United States Court of Appeals for the Sixth Circuit from the Order of Judgment entered on the 5th day of May, 1972 wherein the jury returned a verdict in favor of plaintiff on the Third Cause of Action of the Complaint for maintenance and cure awarding the plaintiff eight ($8.00) dollars per day for a period of June 29, 1968 to June 29, 1970, 731 days for a total of $5,848.00 without interest and costs and from denial of defendant's Motion for Judgment Notwithstanding the Verdict as to said Third Cause of Action, timely filed on May 16, 1972, entered on the 17th day of July, 1972.

FOSTER, MEADOWS & BALLARD
By: /s/ John A. Mundell, Jr.
3266 Penobscot Building
Detroit, Michigan 48226
(313) 961-3234
Attorneys for Defendant-Appellant

DATED: August 14, 1972

OPINION OF THE SIXTH CIRCUIT COURT OF APPEALS DATED AND FILED ON APRIL 8, 1974 — UNREPORTED

Before: MILLER, LIVELY and ENGEL, Circuit Judges.

Per Curiam. The plaintiff, a seaman, alleged in his complaint that he suffered an injury while in the service of his ship. He brought the present action against the

shipowner for damages and maintenance and cure. Jurisdiction in the district court was founded on the Jones Act, 46 U.S.C. Sec. 688 et seq., and the general maritime law of the United States. The jury found that plaintiff was entitled to a limited award of maintenance and cure but denied recovery for damages. Both parties appeal.

The plaintiff was an oiler aboard the S/S "Robert S. McNAMARA". He alleges that in April of 1968, while replacing a lower engine room deck plate, he slipped and fell on the oily floor plate, causing his head to strike an electrical box. There is some doubt as to whether plaintiff reported the accident immediately after it occurred. In June of 1968 plaintiff was discharged from the vessel for failure to follow the orders of a superior officer. At that time the third assistant engineer prepared the discharge papers. He was then informed by plaintiff of the accident that had occurred in April. Plaintiff requested, and was given, a master's certificate which permitted him to go to the U. S. Public Health Hospital in Detroit. Immediately upon leaving the vessel, plaintiff was examined at defendant's plant hospital and was declared "able to work". Subsequently, he was examined on three occasions at the Public Health Service Hospital. After each visit, he was pronounced (sic) "fit for duty."

Plaintiff complained that after the accident he suffered from headaches and dizzy spells. At trial, Dr. Berke, a neurosurgeon, testified that he was unable to find any objective evidence of neurological damage. He did observe that when plaintiff stood with his eyes closed, he could not maintain "complete and perfect" balance. This dificulty suggested to Dr. Berke that plaintiff was suffering from a vestibular disorder—damage to the balancing

mechanism of the inner ear. Dr. Heil, an otolaryngologist, testified that as a result of an electronystagmographic test, he concluded that the plaintiff had a vestibular disorder of the left ear. He stated that he was somewhat puzzled by the results of the test because the report of an earlier examination, by a doctor who did not testify at the trial, showed that a similar test had disclosed a vestibular disorder of the *right* ear. Dr. Heil was unable to offer any explanation for the discrepancy.

The jury found that the plaintiff was entitled to maintenance and cure from June 29, 1968, the date of his discharge, until June 29, 1970. Under the maritime law of the United States, a shipowner is liable to a seaman for maintenance and cure, regardless of the negligence of either party, if the seaman is injured while in the service of the ship. *Aquilar* v. *Standard Oil Co.*, 318 U.S. 724 (1943). The duty of the shipowner to maintain and care for the seaman exists only until the seaman is cured to the maximum extent medically possible. *Farrell* v. *United States*, 336 U.S. 511, 518 (1949). In brief, once the seaman reaches "maximum medical recovery", the shipowner's obligation to provide maintenance and cure ceases. *Vaughan* v. *Atkinson*, 369 U.S. 527, 531 (1962).

The defendant contends that the plaintiff's injury was permanent from the date of the accident and was never susceptible of curative treatment. Dr. Heil testified that although he could not determine from his examination what had caused the vestibular disorder, a severe blow to the head could have caused this problem. Presumably, the jury concluded that it was plaintiff's fall that caused the disorder and the disabling dizziness and headaches. However, the evidence clearly shows that a vestibular disorder is not a condition that can be cured or improved by treatment. When asked whether plaintiff might be cured by treatment, Dr. Heil testified:

> No, not really. Treatment is primarily symptomatic for this condition. That is, people with a vestibular disorder are apt to have intermittent episodes of dizziness which, on occasion, are somewhat more severe. Treatment is limited to those times when the patient is particularly dizzy. They can obtain some symptomatic relief with medication. Other than that, there is no specific cure or treatment.

No evidence was introduced in conflict with this conclusion of Dr. Heil.

The record in this case does not permit an inference other than that plaintiff's condition was permanent immediately after the accident. It is not even alleged that plaintiff has ever received treatment for the condition itself, although he has received medicine for the symptoms of dizziness and headaches. That one may require or be helped by treatment for the symptoms of a disorder does not qualify him for maintenance and cure. *Farrell* v. *United States, supra* at 519. We find that the jury award of maintenance and cure is without material support in the record.[1]

When the jury returned its verdict, the foreman stated that the jury had found no cause of action for either negligence or unseaworthiness because it believed that the

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[1] We are aware that the Third Circuit has taken a very liberal view as to when maintenance and cure may be awarded. *See Ward* v. *Union Barge Line Corp.*, 443 F2d 565 (3rd Cir. 1971). This is definitely a minority position and is difficult to square with *Farrell* v. *United States*, 336 U.S. 511 (1949). *See Berke* v. *Lehigh Marine Disposal Corp.*, 435 F.2d 1073, 1076 n. 3 (2nd Cir. 1970).

accident "was due to the sole negligence of the plaintiff, Julian Vella." Plaintiff contends that the jury's findings on negligence and unseaworthiness were caused, at least in part, by the following instruction:

> [I]f you find the plaintiff was guilty of contributory negligence and that such contributory negligence was the sole cause of his injuries, you must return a verdict for the defendant.

Plaintiff alleges that the trial court committed reversible error in giving this instruction because there was no evidence that the accident was caused solely by the acts of the plaintiff.

As an abstract statement of law, plaintiff is correct when he asserts that an instruction on sole cause is improper if there is no evidence to support such a finding by the jury. *See McCarthy* v. *Pennsylvania Ry. Co.* 156 F2d 877 (7th Cir. 1946). In the present case, however there was sufficient evidence to support the charge and the jury's conclusion. The plaintiff was an oiler on the "McNAMARA" and was responsible for keeping the area near certain moving machinery free from oil. There was evidence that it was his responsibility to remove the very oil upon which he slipped. Moreover, there was testimony that plaintiff used improper procedures in trying to lift rather than slide the plate into place. We are not prepared to find that the record is lacking in material evidence to support the jury's verdict on the "sole cause" issue.

The judgment of the district court is therefore affirmed in part and reversed in part and the action is remanded for entry of an order of dismissal.

UNITED STATE DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

JULIAN VELLA,
Plaintiff,

vs.

FORD MOTOR COMPANY,
Defendant.

Civil Action
No. 34422

JUDGMENT OF MANDATE MODIFYING
JUDGMENT OF DISTRICT COURT

At a session of said Court held in the Federal Building, City of Detroit, County of Wayne, State of Michigan this 7th day of May, 1974.

PRESENT: HONORABLE LAWRENCE GUBOW
United States District Judge

On the mandate of the United States Court of Appeals for the Sixth Circuit in this cause, dated the 9th day of May, 1974, filed herein on , 1974 wherefrom it appears that the Order of Judgment of this Court entered herein on May 5, 1972, has been affirmed in part and reversed in part pursuant to an appeal taken from certain parts of said Order of Judgment by the plaintiff on May 26, 1972, and pursuant to an appeal from certain other parts of said Order of Judgment by the defendant on August 14, 1972, and in obedience to said mandate

IT IS HEREBY ORDERED, ADJUDGED AND DECREED:

1. That paragraph two (2) of said Order of Judgement that the plaintiff fail and take naught against the de-

fendant as to the causes of action of negligence under the Jones Act and unseaworthiness of the vessel be and is hereby affirmed.

2. That paragraph three (3) of said Order of Judgment that the plaintiff be and is hereby awarded Eight Dollars ($8.00) per day for a period of June 29, 1968 to June 29, 1970 under the maintenance and cure action, 731 days for a total of $5,848.00 without interest and costs, be and the same is hereby set aside and vacated, and that the Complaint herein be and is hereby dismissed.

3. That each party shall bear its own costs on appeal.

/s/ LAWRENCE GUBOW
United States District Judge
A True Copy
HENRY R. HANSSEN, Clerk
By /s/ BARBARA H. KONIALEL
Deputy Clerk

* * *

(Tr-140)

AAGE NIELSEN, M.D., being first duly sworn, was examined and testified on his oath as follows:

(Tr-141)

DIRECT EXAMINATION

BY: MR. MUNDELL:

Q Would you state your full name again for the Court and jury?

A Aage Nielsen.

Q Where do you reside?

A 1800 Seminole.

Q What is your profession?

A M.D.

Q Are you duly licensed to practice medicine in the State of Michigan?

A I am, since 1937.

Q Are you licensed to practice as a physician and surgeon?

A Yes, sir.

* * *

Q (By Mr. Mundell) How long have you practiced medicine, Dr. Nielsen?

A Since 1937.

Q Of what school are you a graduate?

A Harvard Medical School.

(Tr-142)

Q Have you taken any special training?

A Five years post-graduate.

Q Where?

A Two years in Detroit, two years at Yale University in New Haven General Hospital and one year abroad in Stockholm.

Q What specialty, if any, Doctor, do you have?

A Neuro-surgery.

Q Are you on the staff of any hospital?

A Yes, sir.

Q What hospitals?

A Harper Hospital, Veterans Hospital, Childrens Hospital.

Q Have you engaged in surgery in your specialty?

A Yes.

Q And you have taken special training in the field of neurology?

A Yes.

Q Would you explain for the Court and Jury, Doctor, what is encompassed in the field of neurology?

A The evaluation and treatment of brain, spinal cord and all the ensuing nerves.

Q Have you held any teaching positions?

A Yes.

Q Where?

A Wayne State University.

Tr-143)

Q Are you currently holding such a position?

A I am.

Q What is that?

A Adjunct Associate Professor in Neurosurgery.

Q To what medical societies or associations do you belong, Doctor?

A The national, state and local medical societies. There is Wayne County, Michigan State and AMA.

Q Do you belong to any societies in your specialty in the field of neurology?

A Yes. American Neurological Society, Congress of Neurological Surgeons.

Q Did you have an occasion, Doctor, at my request, to examine Mr. Julian Vella?

A I did.

Q On what date, Doctor?

A On September 30, 1970.

Q Would you tell us, Doctor, what you did on that date in the course of your examination of Mr. Vella?

A I took as complete a history as I could obtain and I did a neurological examination. I suggested certain tests to confirm my impression from my history and my physical

examination. And then I gave an impression of what I found.

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(Tr-146)

Q Could you tell us what the neurological examination consisted of?

A I did a neurological examination. The patient was five foot four and weighed, at that time, stripped, 182 pounds. He walks normally and stands without a list. That is, straight up and down. The motion of the spine bending forward was what we consider excellent. He was able to touch his toes without bending his knees. There was no tenderness along the entire spine. There was no associated deep muscle spasm of the muscle of the back and the straight-leg raising was within normal limits. That is, you put the patient on a table, flat on his back, and raise the leg up. It could go up to about 90 degrees without difficulty, which was considered normal.

The examination of the head showed tenderness to light percussion in the temporo-parietal region. That's in this area here (indicating). When you touch it like this, the patient would say it was sore. And there was also dimin-

(Tr-147)

ished sensation to pinprick as well as diminished vibratory sense in this area; that is, the temporo-parietal area. And the patient stated that he could hardly feel sensation of vibration over the right frontal area but that he felt it well on the left area of the frontal bone. But otherwise, the head was negative and there were no exostosis or any other abnormality.

The neck was freely movable in all directions; he could bend it forward and backward and there was no tenderness

or associated muscle spasm. There was good bilateral carotid pulsation in the neck. That is, the vessels, when you palpated them in the neck, they felt normal.

The cranial nerves were then examined and sense of smell was normal, intact.

The optic discs were normal. If you took an opthalmoscope and looked into the eyes at the optic nerve, there was no abnormality on that examination. The pupils were equal. They reacted to light and accommodation. The muscles of the eye moved normally.

There was no facial weakness.

The hearing was good bilaterally.

The uvula was elevated in the mid-line. That is the little

(Tr-148)

anatomical—I call it a doo-dad—in the middle of the palate which moves up-and-down normally in the midline.

Other cranial nerves were intact.

The patient's grip was good; 225 on the dynamometer in both hands. There was no evidence of weakness or atrophy of any of the muscles of the extremeties. The deep reflexes were active and equal at the elbow, at the wrist, at the knees and at the ankle, and there were no abnormal or what we call pathological reflexes.

The sensation was intact throughout, except for what I mentioned in the vibratory sense. The finger to nose and heel to knee test were well done. That is, when he touched his nose with his eyes closed with his index finger, that was done normally. There were no abnormal cerebellar signs. He could stand erect without swaying or weaving and the rest of the neurological examination was normal.

Q What is the significance of the finger to nose test and

the finger to finger test, Doctor?

A To see if there are any abnormalities of the cerebellum, going to part of the brain.

Q In the course of your examination then, did you have other tests performed on Mr. Vella?

A Yes, I did.

(Tr-149)

Q What were those tests?

A There were x-rays taken of the skull, an electroencephlographic test and the brain scanning test.

Q What is the purpose of the brain scanning test?

A The brain scanning test is to see if there were any abnormalities which could be shown up by that test, such as collection of bloody fluid underneath the skull pressing on the brain itself, which sometimes happens following injuries.

Q Were there any abnormalities indicated on that brain scan test?

A No, sir.

Q It was normal?

A That was normal.

Q What is the purpose of the electroencephlograph?

A That's essentially the same thing; to see if it varies from the normal EEG. And this one did not. This was a normal test any person with a normal brain would have.

Q And the x-rays of the skull?

A And the x-ray of the skull was entirely negative. There was no evidence of skull fracture or other cranial or inter-cranial injury or pathology by this examination. And any previous injuries were apparently, they thought, to the soft tissues.

(Tr-150)

Q Did you perform any other tests, Doctor?

A No, sir.

Q And at the conclusion of your examination, did you draw an impression?

A I drew my impression from the history, from the examination and from the laboratory studies.

Q What was that impression, Doctor?

A I found that when I saw him, there was no objective evidence of any residual trauma either in the brain, to the spinal cord or the intervertebral disc or any of the ensuing nerves. I made the statement, in addition to that: "It is my impression that if the symptoms of dizziness should persist, an evaluation by the ear specialist might prove helpful." But from my standpoint, a neurosurgical standpoint, I found no basis for symptoms.

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(Tr-2)*

JOSEPH J. BERKE, M.D., being first duly sworn, was examined and testified on his oath as follows:

DIRECT EXAMINATION

BY MR. JAQUES:

Q For the record and to the jury, would you state your name, please?

A Joseph J. Berke, M. D.

Q And you have indicated that you are a physician, M. D. Is that correct?

(Tr-3)

A That's correct.

*Figures in brackets are page numbers of Volume IV of the transcript of the trial proceedings.

Q What is your specialty?

A I'm a neurologic surgeon.

(Tr-5)

Q And Doctor, did you have occasion to examine Julian Vella sometime in the year 1970?

A I did, in my office on April 21, 1970, at your request.

Q And Doctor, would you relate to the jury: Did you conduct a physical examination of the patient?

A I did. I took a history and took a physical examination at that time.

Q And relate, if you will, the history that you took from the patient.

A Mr. Vella stated to me at that time that he was 41 years of age, right-handed. He had worked as an oiler on a coal boat, the ship McNamara. He had not been able to work since April of 1968, according to the patient. At that time he had an accident. He fell, striking the left side of his head against a metal object. He was rendered unconscious for approximately 20 minutes and since that time complained of dizzy spells and headaches. He stated at times it was worse, at other times it was better, but he had been unable to return to work despite a trial of trying to come back. Previous to the accident, his health was excellent. He had no heart disease, lung disease, diabetes or kidney disease. He stated to me that his particular difficulties stemmed from his inability to keep his balance, his loss of equilibrium. Specifically, he was unable to main-

(Tr-6)

tain his balance with his eyes closed and he found that the pitch and roll of the boat caused him increasing dizziness and loss of balance. He told me that he had had no weakness of his arms or legs, he had no loss of sensation. The

headaches occur intermittently but he gets relief from the headaches with mild analgesia. He was born in Malta, came to Detroit in 1947 and told me that he had a fifth grade education.

Q Would you relate to the jury your finding upon the conducting of the examination?

A On the performing the physical examination, the only positive finding was that when I asked him to close his eyes and put his feet together, he swayed somewhat backward and to the right when this was done. But there was no abnormality of his eye signs, there was no particular jiggling movements which we call nystagmus. And I did not find that, on turning his head to either direction, there was any abnormality of balance. The only abnormality I found was the fact that wher he closed his eyes, he could not maintain complete and perfect balance. That usually is expected in a normal individual. His reflexes were normal, strength was normal and sensory examination was completely normal, as were the other modalities tested.

Q What, if any, medical significance attaches to the fact that when he closed his eyes and his feet were together,

(Tr-7)

there was a detection of imbalance?

A This suggests—though it is not diagnostic—damage to the inner ear, the organs of the inner ear that have to do with balance in particular directions.

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Q Did you cause to be taken x-rays of the patients?

A I did. I took x-rays of the skull and cervical spine. These showed no demonstrable abnormality in the bone itself.

Q What was the purpose of the taking of the x-rays, Doctor?

A Well, in taking the x-rays, one would look for any other possible sources of patient's complaints of headaches or dizziness.

Q Did you, at the time after the examination, based on the history taken and the examination conducted, arrive at a diagnostic impression?

(Tr-8)

A Yes, I did.

Q And would you relate to the jury your diagnosis?

A My impression was that Mr. Vella had vestibular damage as a result of a concussion or head injury that he received. I felt that his headaches and dizziness, especially coupled with the positive finding of inability to completely control his balance with his eyes closed, was significant. There was no other neurologic findings to suggest any other cause of his headaches and dizziness; and I felt that since he had worked steadily prior to the incident and was unable to do so after, that there was direct causal relationship between the accident—that is, his hitting his head and his subsequent complaints and inability to work stemming therefrom.

Q And with regard to the concussion—did you find a concussion or did you diagnose a concussion?

A Well, this of course depends upon the veracity of the history given to me. And in an individual who states he hit his head, was unconscious and has certain findings, this diagnosis must be made and can be made by the history.

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(Tr-9)

Q Testimony has come forward, Doctor, during the course of this trial with regard to Mr. Vella having sustained other head injuries aboard other ships and also in the Ford factory relating back, I think, to 1949 or 1951 or quite a number of years back. Now, it also has been borne out that there has not been or was not an absence of employment of any appreciable time at all after the injuries were sustained. There is an indication that there was, as stated by the patient and by Mr. Vella at the time that he did suffer from some dizziness and some headaches. But the question now is with regard to incidents of trauma. Without characterizing those incidents as being major or minor but bearing in mind there was no significant time loss from work, these facts, Doctor, would that have any bearing upon your diagnostic impression with that additional information just related to you?

A I think that those facts would be consistent with the diagnosis and the impression.

Q And what, if any, prognosis were you able to derive, based on the history and the examination conducted and the diagnosis to which you arrived?

A I felt that detailed vestibular tests should be carried out by a good ear, nose and throat person who deals with such problems on a day-to-day basis and perhaps that

(Tr-10)

suggestion by this type of individual might be pertinent toward treatment.

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CROSS-EXAMINATION

BY MR. BALLARD:

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(Tr-17)

Q Now, I believe you said that as a result of your examination of Mr. Vella, with his eyes closed he had some swaying motion. It that correct?

A That's correct.

Q Did that swaying motion exist when his eyes were open?

A He was able to accommodate with his eyes open.

Q So you found no abnormality with his eyes open. Is that correct?

A That's correct.

Q And when you speak of the inner ear, does dizziness in general—or is it sometimes referred to as vertigo?

A It may be.

Q Does that suggest inner ear damage, just the existence of dizziness?

A No. Dizziness is a symptom and it my be caused from many other conditions.

Q And it may be caused by many other conditions than trauma also. Is that correct?

A Certainly.

Q You made no objective findings of any trauma to Mr. Vella. Is that correct?

(Tr-18)

A That's correct. I saw him two years after the alleged trauma.

Q How long did you have Mr. Vella in your office when you examined him, Doctor Berke?

A Approximately an hour.

Q Now, you stated that your diagnosis was vestibular damage attributed to head injury. Is that correct?

A That's correct.

Q But that attribution to a head injury is based on the fact that he told you he hit his head.

A Yes. Solely on the veracity of the patient.

Q In other words, there were no scars or other external evidence on the head to attest to the fact that he hit his head?

A That's correct.

Q What significance do you place on the statement that he was not able to work after this alleged accident?

A I don't think I understand the question.

Q Well, you talked about his working steadily before and unable to work after the accident and you have said that that was just based on Mr. Vella's statements. Now, I would like to know what significance that has in connection with your diagnosis of vestibular damage?

(Tr-19)

A None.

Q So that—do you relate the vestibular damage in any way to his not being able to work at this time?

A No. It is not certainly as a cause or effect or effect the other way.

Q You didn't perform any eye, ear, nose and throat tests on Mr. Vella in your office?

A I did. Some. The general examination of his eyes was carried out.

Q And I believe that you found no abnormality in that—

A In the pupils or in looking into the eyes or in looking at the optic disc and in moving his eyes from side to side, testing those cranial nerves, there was no abnormality. There was no abnormality in looking at the fundi with an opthalmoscope. And I tested anatomically the movements

of his mouth, tongue and throat and there was no abnormality there.

Q And in your report where you state that he was clear, alert and oriented, how did you arrive at that conclusion?

A By talking to him and asking him routine questions that would indicate that to me.

Q And you also found that his cranial nerves were intact.

A That's correct.

(Tr-20)

Q What are the cranial nerves?

A Well, there are 12 pair of cranial nerves. The first one has to do with olfactory function and the 12th one has to do with motor function of the tongue. And in between, there are several which are motor to the eye, moving the eye in various directions, as well as the visual nerve, the auditory and vestibular nerve, which is another one. The 7th is movements of the face. And we can go on if you wish.

Q With reference to his neck, what was your finding in that area?

A The neck was supple. He was able to move his neck throughout the full range of motion. I found no tenderness or spasm.

Q In other words, you found no abnormalities in the neck area. Is that correct?

A That's correct. The only abnormalities I found were those that I related to you with regard to his equilibrium, with the eyes closed.

Q What about his range of motion?

A I found his range of motion full in the lower back as well as the neck and in the extremities.

Q And no tenderness or spasms?

A None.

Q Now, I believe that you discussed post-concussion syndrome. Tell us, what is a syndrome?

(Tr-21)

A A syndrome is a collection of symptoms or signs related to specific disease.

Q And when you say post-concussion, does that mean after sustaining a concussion?

A After a blow to the head, yes, that's correct.

Q That post-concussion syndrome that you are referring to is based on the fact that Mr. Vella told you he hit his head. Is that correct?

A Yes. That he told me he hit his head plus the fact that many other patients who strike their heads have similar symptoms as a result. Some do, some don't to various degrees. And that's determined on an individual basis.

Q But you have no objective finding of any concussion. Is that correct?

A I found no bruise that persisted, no laceration. Only the subjective symptoms of headaches and dizziness and the objective finding of swaying with the eyes closed.

Q But the objective finding of swaying can be attributed to many factors, can it not, other than a concussion?

A This is possible.

Q If the patient in this instance had had prior episodes of dizziness and headaches and feeling something hot in his head, would that indicate to you a pre-existing vestibular

(Tr-22)

condition? Or could it? Let me say that.

A Not necessarily—

MR. JAQUES: I think I will have to register an objection here, your Honor. I think that the doctor can testify as to probabilities within the realm of medical certainty, but to ask a question propounded in the manner where it is possible, I think, that this is within the purview of the jury, I would object accordingly. In other words, if he would couch his question in a manner which would elicit an answer based on reasonable medical certainty as to probability, I think it would be proper.

MR. BALLARD: I don't think that's required in this instance, your Honor. I think the doctor can say whether or not it could have happened, that these symptoms could have suggested a vestibular problem.

MR. JAQUES: But he is asking in the usage of the words and his propounding the question is tantamount to saying, "Is it possible something could have happened" and I submit that the medical expert witness can testify as to matters that go to probabilities and not speculative possibilities.

MR. BALLARD: I disagree with that, your Honor. I think the law is that that goes to the weight of the testimony that the jury wishes to give it.

(Tr-23)

MR. JAQUES: Well, my objection is registered.

THE COURT: I will overrule the objection.

Q (By Mr. Ballard) My question, Doctor, was: Would prior episodes—and when I say prior, I'm referring to before the alleged accident in this instance—prior episodes of dizziness and headaches and complaints of feeling something in his head, could that suggest possible vestibular damage to you?

A I think one would much more suggest vestibular damage if there were impairment of equilibrium because head-

aches and dizziness and bizarre feelings of heat in the head are generalized complaints and not related to any specific organ system.

Q But it is a possibility?

A Well, anything is a possibility.

• • •

Q As I understand your report, you suggested that vestibular examination should be done. Is that correct?

A That's correct.

Q But you did not review or have any opportunity to review any results of any such testing until such time as you looked at Dr. Benitas' report here this morning. Is that correct?

(Tr-24)

A That's correct.

Q So in substance, with the exception of the Romberg test or the swaying with the eyes closed, you found no other neurological objective symptoms in Mr. Vella. Is that correct?

A That's correct.

Q That's correct.

A That's correct.

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REDIRECT EXAMINATION

BY MR. JAQUES:

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(Tr-30)

Q And what is your prognosis, if any Doctor?

A I would defer the prognosis, with newer forms of treatment, to an otologist. And I do not know whether this condition will be permanent or not.

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(Tr-64)*

*Figures in parenthesis are page numbers of Volume VII of the transcript of the trial proceedings.

ROSALIE GARRISI, being first duly sworn, was examined and testified on her oath as follows:

DIRECT EXAMINATION

BY MR. MUNDELL:

Q For the Court and to the Jury, would you state your name, please?

A Rosalie Garrisi.

Q Where are you employed, Miss Garrisi?

A U.S. Public Health Service Outpatient Clinic.

(Tr-65)

Q In what capacity are you employed?

A I'm Supervisor of the Medical Record Department.

Q How long have you been with the Public Health Service Hospital?

A Seventeen years.

Q How long have you been the Medical Records Librarian?

A You mean in charge of the department?

Q Yes.

A Since June, 1969. July 1, rather.

Q Did you receive a subpoena, Miss Garrisi, to appear here today?

A Yes, I did.

Q And to bring certain records with you?

A Yes, I did.

Q Did you bring those records?

A Yes.

Defendant's Proposed Exhibt 27 marked for identification.)

Q (By Mr. Mundell) Miss Garrisi, I show you what

has been marked Defendant's Exhibit 27 and would ask you to look at this and tell me what that is.

A This is the medical record of a patient, Julian Vella.

Q Are you able to identify these as the original record—

A Yes.

Q —of the Public Health Service Hospital? Is this the

(Tr-66)

complete original on Mr. Vella?

A Yes.

Q And were these records kept in the regular course of business of the United States Public Service Hospital?

A Yes.

Q Is it the regular practice and course of business of the hospital to make record of visits and items associated with Mr. Vella's visits to the Marine Hospital?

A Yes. Every time a patient comes in, it is recorded on the record.

Q Are these records under your general supervision and direction?

A Yes, they are.

• • •

(Tr-92)

Q (By Mr. Mundell) Miss Garrisi, I would ask you to turn to the entry of July 9, 1968 in the clinical record. Do you have that entry, Miss Garrisi?

A Yes, I do.

Q Would you read that to the jury, please?

A "Forty year old white male had a steel door hit him on the left side of head three months ago and seen at Ford Clinic. Nothing found. No X-rays taken. No unconsciousness. No headaches, dizziness or other

neural problems. Wants X-rays. Also has some dysuria (phonetic).

"Plan one: U.A."—

which is a urinalysis culture.

"Two: Cervical neck X-rays. Three: Clinic appointment Tuesday. Four: fit for duty."

(Tr-93)

And it was Dr. Rhun.

Q Was Dr. Rhun on the staff of the Public Health Service Hospital at that time?

A Yes, he was.

Q The next entry is July 16, 1968. Would you read that entry to the jury, please?

A He has checked "Report of X-rays," Then he's got "Okay."

U.A., urinalysis culture, negative. Patient feels better. Return to clinic p.r.n."—

Which means as necessary.

—"And fit for duty. Dr. Rhun."

Q The next entry of September 30, 1968?

A "Patient states he has been having headaches ever since June when he hit his head on board ship. All w.u."—

Which is the abbreviation for workup—

"Was negative, including X-rays. Impression: Subjective headaches, no objective findings. Plan placebo. Return to clinic p.r.m. Fit for duty. If persists, will have to do neurological in-patient w.u. Dr. Steven Weinstock."

Q Now, Miss Garrisi, I would ask you to return to the report of the X-ray taken on July 9, 1968.

(Tr-94)

A "Examination of the cervical spine is somewhat limited due to the patient's habitus. Only the upper cervical vertebra are seen in good advantage. There is no evidence of fracture or displacement. The intervertebral disc space heights are well maintained throughout. Impression: Substandard but grossly normal examination of the cervical spine. Harry J. Waldman, M.D., Chief Radiologist."

Q I would refer you back to the entry for July 9, 1968. I believe I understood you to say, "Seen three months ago —seen at Ford Clinic."

A Uh-huh.

Q There is a dash between "three months ago" and "seen at Ford Clinic."

A That's correct. After "three months ago," there is a dash. Then there's "seen at Ford Clinic" and a dash.

Q Fine. Miss Garrisi, I would ask you to turn to the entry for July 23, 1958.

A July 23, 1958?

Q Yes.

A "Temperature 98.6. Patient bumped top of head 7-8-58 without loss of consciousness and only transient headache. Now for several days he has had some mild right optical pain radiating down right

(Tr-95)

shoulder slightly. No other symptoms except slight nervousness. Examination of cranial nerves normal D.T.R."

I don't remember that abbreviation, what he means by that.

Q But it reads "D.T.R. normal"?

A Right.

"Motor nerves normal. Some tenderness over left"—

It looks like occipital and trepenzen. It's Dr. Reed's writing and it looks like trepenzen.

Q The impression?

A "Tension headache. Treatment: a.p.c.'s., one every for hours."

And there's some other medication there; "One grain three times a day."

Q And the entry for July 28, 1958?

A "July 28, 1958: Headache practically gone. Food handler examination okay. Dr. Van . . ."

I do not remember what doctor we had back then.

Q All right. Now, one last entry on July 24, 1963.

A July 24, 1963?

Q Yes. I would just ask you if you will—it will only be necessary to read down through "no chills" there. Just the beginning portion of that.

A July 24, 1963—

(Tr-96)

Q I'm sorry, July 7, 1964.

A Oh, July 7, 1964.

Q Yes.

A "36 year old man complaining of fatigability while at work, of 40 days' duration. He has had one episode of a.m. (dizziness) which I can't get him to describe better and nausea without vomiting. Has had sensation of 'something hot in the head' without actual headache. No chills, no change in usual one to two stools daily. No malina."

Q I believe that's all we need Miss Garrisi.

A Okay.

MR. MUNDELL: That's all the defendant requests from the record, your Honor.

THE COURT: Do you have anything, Mr. Jaques?

MR. JAQUES: No. Miss Garrisi may be excused as far as we're concerned.

THE COURT: All right, Miss Garrisi. Thank you. You may step down.

MR. MUNDELL: Thank you, Miss Garrisi.

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(Tr-97)

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DAVID CHARLES LADERACH, M.D., being first duly sworn, was examined and testified on his oath as follows:

DIRECT EXAMINATION

BY MR. MUNDELL:

Q Will you state your full name to the Court and jury, Doctor?

A David Charles Laderach, M.D.

Q Will you speak right up so we can hear on this end of the jury box?

A Yes.

Q What is your profession, Doctor?

A Medical Doctor.

Q Where are you employed, Doctor?

A I'm employed by the Ford Motor Company at the Central Medical Services, the Rouge area, in Dearborn, Michigan.

Q In what capacity are you employed?

A Physician in charge of the hospital.

Q How long have you been in that position?

A I have been in the particular title, position, two years.

(Tr-98)

But I have worked as chief physician for 12 additional. So it's a total of 14 years in that area.

Q Are you duly licensed to practice as a physician in the State of Michigan?

A I am.

Q Would you tell us, Doctor, what medical schools you have attended and what medical training you have had?

A I graduated with an M.D. Degree from Ann Arbor or University of Michigan in 1946. I had a year of internship at Luther Hospital in Clair, Wisconsin. I went to the army for two and a half years and then started postgraduate training in internal medicine, first year, at the University of Cincinnati, and the last two years as resident in internal medicine at Harper Hospital in Detroit.

Q Do you specialize in any particular field of medicine, Doctor?

A Internal medicine.

Q Have you had any special training in that field?

A The three years. The one year at Cincinnati and the two at Harper.

Q Do you belong to any medical societies or organizations?

A Yes. The American Medical Association and the Michigan, State and Wayne County Medical Societies.

Q Were you requested to bring certain documents with you today, Doctor?

(Tr-99)

A Yes. I have here the complete records on this case.

Q May I see that file for a moment?

(Defendant's Proposed Exhibit 28 marked for identification.)

Q (By Mr. Mundell) Doctor, I show you what has been marked Defendant's Exhibit 28 for identification and I would ask you to tell us what that is?

A This is what we call a patient's jacket which contains the complete record from the time of hire at Ford Motor Company until the time of discharge. This would be the complete periodic examinations that the patient received, any correspondence between our hospital and the outside physician who may be taking care of the patient for a private illness; it would also contain his prescriptions for work which show us any work restrictions the patient might have. It would also contain his eyeglass prescriptions and other laboratory data that would be routinely performed in any periodic examination.

Q And this is the file on an individual, Doctor?

A This is the file on one Julian Vella, V-e-l-l-a.

Q Were these records made in the regular course of business of the Rouge Plant Hospital, Doctor?

A They were.

Q It is the regular practice in the course of business of the hospital to make an entry of the visits of Mr. Vella

(Tr-100)

to the hospital and is this the original record?

A This is the policy on every employee, to have such a jacket with such entries, yes.

Q Where are these records kept?

A These records are kept at Central Medical Services in an alphabetical file.

Q And these are kept under your general supervision and control as physician in charge?

A That is correct.

MR. MUNDELL: I would offer into evidence Defendant's Exhibit 28, your Honor.

MR. JAQUES: We would have the same objections and to that extent.

THE COURT: Do these records go beyond that which the Court ruled on in the previous exhibit?

MR. MUNDELL: No, I do not believe they do, your Honor.

THE COURT: All right. The objection is noted and I will admit it subject to the same limitations; that it can deal only with injuries to the head, neck and spine.

MR. MUNDELL: Thank you, your Honor.

(Defendant's Exhibit 28 received in evidence.)

Q (By Mr. Mundell) Dr. Laderach, would you tell the

(Tr-101)

jury please, what the procedure is at the Ford Plant Hospital in regard to keeping of hospital records?

A Yes. The matter of privilege communication between a doctor and his patient comes in here and we have two situations. We have the records divided into two parts. One part is a confidential record, the one marked Exhibit 28. This would be a confidential record, the contents of

which could not be released by us to anyone unless there was an authorization by the patient to discuss the contents of this envelope. In other words, this would be his private medical history and physical examination that would compose one-half of the filing system. The other half of the filing system I have in my right hand. This would be the records of injuries sustained during the working period of the employee kept on what we call Form 5130.

When someone is injured at the Ford Motor Company, there are other people that must be involved in the course of the case. There has to be the safety man who inspects the site of the accident. There has to be the compensation man who investigates the compensation aspects of a case. There have to be the doctors and nurses that treat the case medically. So that when you are hurt at work, we make up a card on each injury and then this part of the file is open to those people who need to be involved in the

(Tr-102)

care of the case. The doctors, the nurses, the compensation man, the safety man, any people in industrial relations may look at the compensation record whereas only the doctors can look at the private medical record. So our cases are divided into two parts: One private and one compensation.

Q Doctor, is a record kept of every visit that an employee might make to that hospital?

A Every visit is recorded. Now, if the—in this jacket marked Exhibit 28, there would be a health record that would deal with the private medical problems that the employee would have during the course of his employment. These would not be injuries. These would be things like headache, colds, any complaints that the man might have that would not be related to an accident. This would be

placed on the health record and each visit is recorded separately and this again is privileged communication between the doctor and the patient and is not released to anybody else and therefore it goes into this particular jacket.

Q Would you tell us what the procedure followed by the hospital is in regard to the issuance of medications?

A Medications would be issued in all cases according to need. They would be given as much for private medical illness that were complained of during the course of the

(Tr-103)

working day or they would be given as routine prescriptions for and relative to injuries sustained on the premises of the Ford Motor Company during the working day.

Q Is there a record made of medications issued?

A The record of medications for private illnesses would again be in the privileged jacket and the record of medications given in cases of injury would be recorded on the Form 5130.

Q Is medication ever given without it being recorded, Doctor.?

A Never.

Q Not even an aspirin?

A Not even an aspirin.

Q Well, Doctor, you were employed at the plant hospital in 1968. Is that correct?

A I was.

Q And at that time I believe you testified you were the head physician.

A The chief physician of the hospital, yes.

Q Did you have occasion to see Mr. Vella in 1968?

A I did, as recorded on the 5130.

Q A record was kept of this visit. Is that correct?
A That is correct.
Q Do you have that record in front of you?
A I do.
Q Referring to that record, Doctor, would you read to

(Tr-104)

the jury what is contained on that card which relates to a visit in June; on June 29, 1968?

A Do you want me to read every line on the card?
Q Yes, if you will.
A Beginning in the upper left-hand corner and progressing to the right:

"Name: Vella, Julian. Social Security number: 089-24-7611. Date reported: 6-29-68. Time: 10:05 a.m. Date of onset of illness: Three months ago. Badge Number: Salaried employee, Department 80. Plant or Building: SS McNamara. Staff Division: Marine. Present Occupation: Oiler. Age: 40."

Then follows the statement of the injury in the patient's own words:

"My foot slipped while replacing lower engine room deck plate and I hit my head against electrical contact box."

"Diagnosis: Alleged left parietal contusion."

Do you want me to go into the explanation of the meaning of the words?

Q We'll go back to that, Doctor. Just tell us now what you did after Mr. Vella related to you what had happened?

(Tr-105)

A After the history—he of course gave this history to one of our nurses who of course added the additional com-

ments on the other side of the card and then I was called to see Mr. Vella.

The back of the cards states:

"Date: 6-29, 10:10 a.m. Complaint of soreness and 'jumping sensation in the left parietal region' as of last three months. Complaints vague. No apparent swelling, discoloration or healed laceration noted. Denies visual difficulties, nausea, vomiting. No dizziness. Age 40. Blood pressure 126/80. Pulse 80 regular, good volume. Temperature 99."

And that is signed by the nurse. These were the nurse's observations.

Then I was called to see the patient and the next portion is in my handwriting.

"Note late reporting date", referring back to the fact on the front that the date of onset was three months before the injury was reported.

"No neurological deficit. No central nervous system symptoms. Patient explains the left parietal sensations as 'electrical'. No headache. Eyes, ears, nose, throat, extraoccular movements are normal. Pupils equal, responding to light and accommoda-

(Tr-106)

tion. Fundi not remarkable."

Then the contents of the second card, which is the continuation of the examination of 6-29-68:

"Ears not remarkable. Cranial nerves intact. Refraction is equal, plus one and uniform. Romberg negative. Finger to finger and finger to nose normal. Co-ordination good. Affect and sensorium normal. Complaint may relate to a tiny nerve branch contusion."

The back of the card is a continuation of the visit of 6-29-68:

"Treatment: One, Darvon Compound capsules, one every four hours; two, cold packs 30 minutes b.i.d. Able to return to work? Yes. Advise date next treatment: Discharged. Treated by myself and my signature, D. C. Laderach."

On the front of it:

"Disposition: Regular work."

Q Referring to the front of the card, under diagnosis you show, "Alleged left parietal contusion." Would you illustrate for the Court and jury where the left parietal area would be?

A The left parietal area of the skull is just posterior to the temporal area which is here (indicating). The parietal

(Tr-107)

is above the ear. So in the area of the ear and on the left side. And contusion means a blow struck to that area. So we have a left parietal contusion or blow.

Now, the word alleged precedes the diagnosis. The word alleged has a special significance to me in that I never write it on a record and I wrote this on the record because of the peculiar circumstances of the method of reporting the injury. When we use the word alleged, we are—in my mind, this is my own personal interpretation of what I mean by the word alleged. I'm saying to myself that the patient alleges that this occurred. And when I use the word alleged, to me, when I look at my records, it means that there is some doubt that I have. I feel that it is customary when we break a leg, for instance, to seek immediate help. When we see a date of onset of an injury three months before the patient sees the doctor, then I think that this is a peculiar situation and that's why I used the word alleged. Ordi-

narily, I would just say, "Left parietal contusion". But because I was in doubt because of the lapse of time between the date of the injury and the time of reporting three months later, I did affix the term alleged to the front of the diagnosis.

Q Thank you, Doctor. Now, would you refer to a similar card for an accident that occurred on December 26, 1956.

(Tr-108)

Do you have that card in front of you?

A I have that card, 12-26-56.

Q Would you be good enough to read to the jury the complete contents of the record.

A Yes.

"Name: Vella, Julian. Social Security number 098-24-7611. Date reported: 12-26-56, 7:40 p.m. Department: Dearborn Assembly Plant. Date of onset: 12-12-56 at 7:13 p.m. Statement: 'This thing looks like a drill. I lifted my head up and hit my head. It made me a little dizzy and head sore here.' Indicates left temporal region. Diagnosis: Claims contusion, left temporal region. No loss of consciousness or headache."

Now, this would be the nurse's portion of the record on the back:

"12-26-56, 7:63. History uncertain. Referred to main hospital."

Then he was seen at the main hospital, Central Medical Services, and the next thing was:

"Neurological examination negative. Discharged with advice to use ice caps or cold. Discharged."

Then the next entry is the next day. 12-27, 11:45 p.m.:

(Tr-109)

"Complains of dizziness. Temperature 98. Blood pressure 130/90. Neurological exam negative. Phenobarbital, grains ¼, no. 4 tablets, one every four hours, p.r.n. for dizziness. Diagnosis: Anxiety reaction. Able to work? Yes. Advise next treatment: Discharged."

He was treated by Dr. Reed. The next entry was 1-8-57:

"Recurrent dizziness. Discharged. To return on 1-9-59 to see Dr. Block."

Then the next entry—I'm going to the second card now—is on 1-8-57:

"Was discharged by the company for unsatisfactory work. Says he cannot get job because he looks dizzy."

This was signed by Quigley, who is one of our nurses' supervisors.

"Advised next treatment: The following day."

So the treatment on 1-9-57:

"A skull X-ray was taken. The X-ray was negative. It was interpreted by Dr. O'Hare, follows Dr. Block's examination. Patient notes momentary dizziness when moving his head quickly. Also notes mini-

(Tr-110)

mal soreness at the site where he struck his head on 12-26. Has not fainted or had any neuro-muscular symptoms. Cranial nerves intact. Fundi normal. No muscle weakness. Motor functions normal. No other neurologic abnormalities. Ears are normal. Advise: Phenobartital, grains ¼ Q.I.D., p.r.n., dispense 12. Able to work? Yes. Discharged for p.r.n. or return as necessary."

It was signed by Dr. Block.

On 1-10-57, a note to Compensation.

On 1-16-57 at 3:45 p.m., again Dr. Block:

"Blood pressure 110/78. Patient now states he has headaches occasionally in addition to symptoms noted above. None of these symptoms are persistent or severe. Patient has no symptoms at present. He states he had a headache on Monday, January 14, 1957. He maintains he is unable to get a job anywhere and the reason he was discharged here was because he injured himself. I explained to the patient that symptoms which he has are not particularly significant at the present time and on the basis of the examination done, indicated nothing of a serious

(Tr-111)

nature. He was further advised that symptomatic treatment is the only treatment indicated at present and if he has headaches, he should take aspirin, grains 10, every four hours p.r.n. or as needed. If symptoms persist for any length of time or become more frequent or severe, he should return for evaluation. He was also told that we would not authorize payment for outside medical service inasmuch as the medical service was available to him here if he needs it. Patient is quite argumentative and somewhat beligerent, especially about his being discharged from the company. He was told there was nothing that the medical department can do about this situation and advised next treatment as necessary. Dr. Block."

The next entry is 1-21-57:

"My head aches where I was hurt and I'm dizzy. I did not take aspirin; I took too much already."

1-21-57, Dr. Block's entry:

"Patient states he still notes intermittent momentary dizziness and intermittent headache which is relieved by aspirin.

(Tr-112)

"However, he notes aspirin makes him vomit. No other neuro-muscular symptoms to leading questions and present symptoms are not increasing in frequency or severity. Complete neurological examination remains negative in its entirety. Treatment: One, enteric-coated sodium solicilate tablets, two every four hours as needed; two, Bonamine, 25 milligram tablets, one b.i.d. as needed for dizziness. Return one week. Dr. Block."

That was the 21st. On 1-25-57 at 10:30 p.m.:

"States he started working with Persueus Boat Company as fireman on 1-25-57. He still is dizzy and stomach upset from medicine and cannot eat."

This is Dr. Rabe's note, who is a psychiatrist on our staff:

"This man is a very disturbed, passive personality who is desirous of being taken care of. His somatic symptoms are his unconscious way of forcing people to take care for him. He was given sodium solicilate again and oscillidoes"—

Which is a solicilate compound—

(Tr-113)

"two tablets twice a day for four days. Dr. Rabe."

That is the end of the record marked 12-26-56.

Q Doctor, I'll ask you to take a similar card for the accident of August 6, 1966.

A I have a card dated 8-14-66.

Q I'm sorry, that's it.

A The injury card of 8-14-66:

"Vella, Julian. Social Security number 089-24-7611. Date of report: 8-14-66. Time: 5:20 a.m. Plant or building: Henry Ford II. Date of onset: 8-6-66. Present occupation: Oiler. Time on present job: Four months, Age: 38. Address: 1413 LaBross, Detroit 16.

"Statement in patient's own words: 'I bumped my head on exhaust pipe on main engine when I raised up after opening valve and my head is still sore and I have headaches.'

"Diagnosis: Contusion to the frontal region of the scalp.

"8-14-66, 5:20 a.m. Temperature 98.6. No swelling or sign of any injury.

(Tr-114)

"Pupils equal, reacting to light. No nausea or dizziness. Given A.P.C., number 16. Able to work? Yes. Advised date of next treatment. Return is needed. Nurse Callas."

An entry of 8-20-66:

"Not reporting", at which time that particular chapter was discharged.

That's the content of that card.

Q Thank you, Doctor. Now, could we go back for a moment or two to the card where the visit of June 29, 1968 was recorded?

A June 29, 1968.

Q That's correct. In the course of your examination, a Romberg Test was given. Would you explain to the jury what the Romberg Test is and the purpose of that test?

A Yes. When there is a contusion to the head, we have to check all components of the central nervous system. And the complaints that patient who has a head injury gives are of course diffuse and multiple. That can be most commonly headaches, dizziness, nausea, vomiting, lethargy, sleepiness, unconsciousness, fainting. We can take it from there and go on and on, but those are the most frequent ones. So we have tests to explore the symptomatology; and the Romberg Test is a test that explores the patient's complaint of dizziness. The medical term of that is vertigo.

(Tr-115)

So that when we say the Romberg is negative, we mean that the patient is asked to put his feet together standing up erect and close his eyes; and if the patient does this and wavers, we are suspicious that his balance is off. It's quite a difficult test to do if you are dizzy and you would tend to fall. So that when we say the Romberg test was negative, we mean that the patient stood erect with his feet together and his eyes closed without wavering in any direction.

Q And the Romberg symptom of wavering with his eyes closed, could that be feigned by the patient, Doctor?

A It could be feigned. And the next two tests are a little more difficult to feign and that's why we went a little further.

Q What are those tests?

A These are called the finger to finger test and the finger to nose test. They are a little more obscure because the patient may not know what these tests are for. And these are tests which locate points in space and they tell us whether the person is oriented as to his special relationships. Now, these are performed again with the patient erect and his eyes closed. First of all, finger to finger:

This is sort of—may I demonstrate?

Q Certainly.

(Tr-116)

A The finger to finger test is done with the patient standing erect and his eyes closed and his arms extended like this. And we say, "Now take your index fingers and with your eyes closed touch the tips of your index fingers together." And we sort of mix him up with the arms around him and say, "Okay. Now, touch the tips of your fingers together." With your eyes closed, this can be very difficult and you go like this and you touch your fingers together with your eyes closed. Now, if you are dizzy or have any illness where your spacial relationships are mixed up, you do this or that and you overpoint and you cannot find your fingertips in space. So if you, with your eyes closed, touch your fingers like this, we know that you are oriented as to space and depth.

In this instance, the finger to finger test was normal. The patient was able to do that. If you are dizzy and you are wobbling around, your fingers are doing this, too, to the extent that you are dizzy. And again, you cannot find your fingertips. So that when we say the finger to finger test was normal, we are meaning that he was able to locate the finger to finger with his eyes closed standing erect with his feet together.

Now, we do the same thing as an extension of this in the finger to nose test. And again the patient stands erect

(Tr-117)

with his eyes closed, his feet together, and he touches the tip of his nose. If you are mixed up or are dizzy, you cannot find the tip of your nose and you overpoint. You think your nose is over here or here or down here and it's hard

for you to find the tip of your nose. You do that with the right hand and do it with the left hand and it's sort of hard to do and it's especially difficult to do if you have what neurologically we call vertigo, which is dizziness.

So that on the card, the Romberg was negative, the finger to finger was negative and the finger to nose was normal, meaning that the spacial relationships were all intact. And from this we would conclude that there was in fact no organic sign of the patient being dizzy.

Q Thank you, Doctor. On June 29 then, you prescribed some medication.

A Yes. On —June 29, 1968, I prescribed Darvon Compound, 18 in number, capsules, one every four hours.

Q Doctor, I show you what has been marked Plaintiff's Exhibit 8 and ask you if you can tell us what that it.

A May I look at it?

Q Yes, Doctor. You may examine the contents also.

A I see a pink—shall I take one out?

Q Yes.

(Tr-118)

A I see a pink and gray capsule with the Lilly Pharmaceudical Company's name on it. And this is Darvon Compound.

Q Is that what you prescribed on June 29?

A That is what I prescribed on 6-29-68.

Q Can you identify the envelope?

A The envelope is the standard Ford Motor Company envelope, Industrial Relations, July, 645144. This is the standard envelope that we present to the patient with medication in it. The nurse presents this to the patient.

Q Are the directions on that envelope, Doctor, in accord with your prescription of June 29, 1968?

A "Capsules One q. 4 h. Take one capsule every four hours as needed for soreness." That's correct.

Q What is the practice of the hospital when it comes to dispensing drugs or medication such as this?

A The policy is to have the 5130, which is the card from which I read, read by the nurse. The nurse then asks the doctor any details about the prescription. And then the nurse fills the prescription in this envelope and hands the envelope to the patient.

Q Is there a record made that the medication has been given?

A The record that I have is the record of the medication.

Q Is medication ever given without a record being made?

A No, medication is never given without a record.

(Tr-119)

Q Is there anything unusual about that particular envelope that comes to your eye?

Y Yes. Now, I notice that there is writing in the upper right-hand corner. Is that the exhibit writing?

Q Yes, that's the Court—

A It's an initial and a number and a D. That does not belong to us.

The directions on this envelope are peculiar in that on the fourth line of the exhibit, there appears a date, 4-4-68. This record is dated 6-29-68. So there is a difference in the date on the medical record and a difference on the envelope with the medication. This says 4-4-68. Now, this is against our Ford Motor Company policy. We never date the medication envelope. We have the date on the medical record and when this envelope is presentd to

the patient, it contains the medicine and the instructions only and our nurses do not put the date on this little envelope. So I would have to assume that somebody else wrote this date on this envelope because it is against our medical policy.

Q Now, Doctor, I would ask you to refer to your record insofar as visits to the plant Rouge Hospital by Mr. Vella and tell us if there is any entry showing a visit by Mr. Vella on or about April 3 or 4, 1968.

(Tr-120)

A None of the records of injury—do you want me to repeat the dates on these cards?

Q No, just review them, if you will.

A All right. On 4-3 or 4-4-1968?

Q Right.

A On the cards of injury, there are no visits of 4-3 or 4-4-68.

Shall I look at the medical jacket?

Q Yes. Is there anything in the record anywhere showing a visit by Mr. Vella to the plant hospital on 4-3 or 4-4-1968?

A On the private health record, there is no such date.

I have no record of such date, 4-3 or 4-4-1968, in the medical file.

Q In that same file, Doctor, before you put it away, I would ask you to refer to a physical examination of March 11, 1966.

A 3-11-66, yes.

Q Is there an indication there, Doctor, of hearing or ear problem of any kind?

A The physician who signed this on 3-11-66 noted in Item 29: "Ears: Borderline left ear." So I would look

at the audiogram for that. And on the audiogram of 3-11-66, I notice that at 4,000 cycles per second and at 6,000 cycles per second, in the left ear there is a moderate hearing

(Tr-121)

loss of 40 decibels and 35 decibels. This would be what the physician, the examining physician of 3-11-66, clued us in on in the physical when he referred to borderline left ear. The audiogram shows what he meant.

Q Yes. Now, Doctor, you have specified this is the complete medical file on Mr. Vella.

A That is correct. That we have.

Q Qualified perhaps by the absence of actual X-ray films. Would that be correct?

Q And there would be no other record kept on Mr. Vella had he come to the Ford Plant Hospital in the Rouge area.

A That is correct. No other records.

Q And if Mr. Vella came to the plant hospital in the Rouge area on or about April 3 or 4, 1968, it would be reflected in that record, would it not?

A It would be reflected in this record, yes.

Q And if medication such as Plaintiff's Exhibit 8, the Darvon Capsules, was given, it too would be recorded in that record.

A That is correct.

MR. MUNDELL: Cross-examine.

CROSS-EXAMINATION

BY MR. JAQUES:

Q How long did you say, Doctor, you have been with Ford?

(Tr-122)

A A total of about 14 years.

Q And you did say that you are a specialist in internal medicine?

A Board qualified in internal medicine.

Q And when you say Board qualified, you mean you have not passed the examination for admission to that special society pertaining to the recognizing of the internal medicine specialists with the American Medical Association.

A This term refers to having completed the training for qualification for examination. I did not take the examination. I completed the training and then I went to the private practice of cardiology for two years and then to the Ford Motor Company.

Q But as a matter of fact and just so we understand, you are saying that you have completed the training but you haven't gone further to be certified as a specialist in internal medicine.

A That is correct.

Q So it would be something like somebody completing a program of study without taking the test to become, let's say, a lawyer or doctor or whatever, in that sense.

A Many people practice internal medicine without these examinations.

Q Oh, yes. As a matter of fact, you are licensed to practice—

(Tr-123)

A You are licensed to practice anything.

Q As long as you have a medical license.

A That is correct.

Q But insofar as recognition among the American Medical Society is concerned with regard to the specialty, there's the various boards of specialization.

A That is correct.

Q And you are saying you don't belong to one of these boards.

A That is correct.

Q And Doctor, let's see; this has been 14 years that you have been with Ford.

A That's right.

Q You speak in terms of the hospital. You don't mean the hospital on what is the Grand Boulevard. You don't mean the Ford Hospital there, do you?

A No. I'm talking about the Central Medical Services Hospital in the area at which we work at the Ford Motor Company in Dearborn and I identified it as such.

Q So that is a hospital for employees only. Isn't that true?

A That is a hospital for employees only.

Q And is it a hospital in the sense of having beds wherein patients are—

A Yes.

(Tr-124)

Q There are people right there?

A What?

Q How many beds do you have?

A We have six beds in the area for the treatment of occupational illness attended by fifteen physicians and 89 nurses.

Q So you've got six beds. It's a six-bed hospital.

A It's a hospital that relates only to the treatment of occupational injuries. Therefore, it is of very limited scope

because not all of our illnesses are occupational.

Q But the thing is, it's more of an emergency kind of—

A It is an emergency setup, although we have kept patients as in-patients as long as five weeks.

Q Sure. But you don't really mean to say that this is a hospital comparable to some other type of hospital where—

A It is a hospital that is peculiar to the needs of our company. We have round-the-clock nursing care, round-the-clock doctor's care. We have a registered laboratory technician for all the lab tests. We provide the patient with meals, with all the facilities that a hospital would provide. Only, however—and this is how it differs from other hospitals—only in cases of occupationally incurred illness or injury.

Q And so it would be fair to say then that this is essentially an emergency room kind of operation with regard to

(Tr-125)

industrial—

A Emergency room is only one aspect of our function.

Q May I finish, please? With regard to industrial accidents.

A May I answer now?

Q Please do.

A The emergency room is one aspect of the hospital. There are multiple facets to the operation of our hospital. Emergency room is one of them.

Q And then the other facet would be the six beds.

A That is only one other. There are other facets.

Q And then the other facet perhaps would be continued treatment with regard to some kind of industrial accident that may have occurred. Out-patient service. Is that right?

A May I amplify on that?

Q Please answer. If you need to, amplify. But please answer.

A Right. We have in the hospital an entire department in industrial hygiene and toxicology. And there is a staff that checks the working environment of the employees, the air sampling of the atmosphere for pollutants and contamination. It checks the noise levels. You notice we had the audiogram discussed here. Another aspect of the hospital's function is to check into noise levels. We have a physiotherapy department which supplies all modalities of physiotherapy. That would be diathermy, whirlpool,

(Tr-126)

ultra-sound, heat, et cetera. Our x-ray department takes X-rays. We have a treatment department which you described as an out-patient clinic and we have nine examination rooms for periodic examinations plus the private doctors' offices. Plus a pharmacy that is fully stocked.

* * *

Q Are you doing anything about the environment and pollution and things? Are you doing anything about that?

A It's quite interesting to me. The Stamping Division of the Ford Motor Company just approved six million dollars worth of engineering controls for noise. I think it's a great step forward. It's a colossal job to control the environment. We're making inroads hopefully.

Q And you would agree it's about time, isn't it?

A Oh, it's long overdue, sir.

Q And with regard to emergency treatment, the hospital is open 24 hours. Is that right?

A That is correct.

Q And you are there how many hours?

A We're there—the regular staff of which I'm a mem-

ber is there from 8:00 o'clock in the morning until 5:00 at night and we split weekends. The part-time staff takes over at 5:00 o'clock and works until midnight and then the midnight staff works until the morning hours and overlaps with us. So it's 24 hour coverage.

(Tr-127)

Q And you indicated that you have 89 nurses.

A Nurses and paramedical personnel.

Q So paramedical would mean men with white coats and this kind of thing?

A This would be licensed practical nurses, licensed medical assistants and nine first-aid men who are ambulance drivers and so forth.

Q And they wear white coats?

A They wear white coats.

Q And the nurses, are they all female nurses or do you have both male and female nurses?

A We have both registered female and registered male nurses.

Q The practical nurses, are they both male and female?

9 The practical nurses are licensed, both male and female, yes.

Q Do you have nurses' aides?

A No, we do not. We have medical assistants who are female.

Q Okay. And the shift comprises of what complement?

A Now, I—

Q Well, I understand that you have a shift from 8:00 o'clock in the morning until 5:00 in the afternoon.

A Right. There would be seven physicians staffing the hospital during the 8:00 o'clock to 4:30 or the 8:30 to 5:00 o'clock shift. There would be two physicians staffing the 5:00 o'clock to 1:00 o'clock shift. And then there would be

(Tr-128)

one physician staffing the 1:00 o'clock to 8:00 o'clock shift. So there is an overlap.

Q So you do have it down to one physician at the time, then.

A The midnight shift is by far the more quiet of the three and it necessitates only a lighter coverage. Now, that applies to nurses as well as doctors.

Q And how many of those paramedics are there in the daytime?

A No, with a staff of 83 nursing personnel, I would not have the schedule to look at. I would not be able to tell you exact number of registered nurses, medical assistants and licensed practical nurses on all three shifts. It would be hard for me to visualize that just in a second.

• • •

THE COURT: Will counsel approach the bench, please?

(Whereupon an off the record discussion was had at the bench between the Court and counsel.)

MR. JAQUES: Your Honor, I'll try to hurry through just a few things.

Q (By Mr. Jaques) In 1968—would you refer to your card, please, the one that you did refer to, and you put down—I think it would be like—well, I don't know how it looks on your card, but anyway, on the entry of the 29th—

(Tr-129)

A Yes.

Q —I think the last entry there—see, what happens, they have been photostated here and I suppose you have two sides to the card. But where you've got, "Complaint may relate to tiny nerve branch contusion," was that not a—some type of diagnostic impression made—

A Yes, that was an impression.

Q Yes. And you did not go further, did you, in exploring—you did not go further in exploring the matter?

A No. If you will notice, the fact that the patient was discharged meant that I thought the complaints were minor and this was merely a passing impression and I thought that the cold packs, which was the second thing I prescribed, would be of aid to this electrical feeling that the patient described in the left parietal area. Cold is an anesthetic and so I thought cold packs or ice packs would anesthetize the electrical area in the left parietal part of the skull.

Q Now, Doctor, would you just do this if you can? And I don't mean to restrict you. But just answer my question and kindly don't amplify. Just answer my question because I do want to finish up. We should be finished now and I want to do it quickly.

So it is true, is it not, that you did make a diagnostic impression of some type of contusion relating to a nerve

(Tr-130)

branch?

A No.

Q You did not?

A The diagnosis is on the front of the chart.

Q Doctor, please. Is this not a diagnosis when you say—

A This is an impression.

Q All right, impression then. Is not an impression at least a preliminary diagnosis?

A It leads in that direction. But I do have the diagnosis on the card.

Q I understand. You've got another diagnosis on the front of the card.

A Right.

Q All I'm asking you is: Is this not a medical opinion right here?

A It is a medical opinion or impression.

Q Okay. As to what is wrong with the patient.

A That's correct.

Q Okay. But I think generally people who are not doctors, like myself, and I'm sure the judge and the jury, we think of diagnosis as being a medical opinion with regard to an ailment. Would you—

A I would agree with that.

Q Fine. So you further gave a prescription of Darvon and cold pack.

(Tr-131)

A That is correct.

Q Now, with regard to prescription, if you prescribe, you do not recklessly prescribe, I would assume, do you?

A That is correct.

Q And by your being a medical doctor, you would say you are a scientist, aren't you?

A Yes, sir.

Q And so when you do make a prescription with regard to drugs, you do this because you at least believe that there is some need for the prescription?

A Yes.

Q And with regard to matters of the ears, nose and throat and that kind of thing, you don't have any record pertaining to any of this having been done by the Ford Motor Company, like an E.N.T. examination or anything like that?

A Yes.

Q I'm sorry. Not E.N.T. E.N.G.

A No. E.N.G. is a specialized nystagmus test done by

an otologist.

Q Right. And you didn't have that performed?

A No.

Q And you, as a matter of fact, did not diagnose a vestibular disorder in Mr. Vella.

A I diagnosed quite the opposite.

(Tr-132)

Q That he didn't have one.

A That he did not.

Q And an E.N.G. is the kind of objective testing that would show a vestibular disorder. Isn't that correct?

A That is one of the specialized tests that would help in that direction.

Q And that's one test that you can't fool with in the sense that the patient can't feign it or use any—

A That's correct.

Q In other words, he has no control.

A That is correct.

• • •

Q And with regard to medical examinations for seamen going aboard your ships—when I say "your", I mean the Ford Motor Company ships—do you give the seamen examinations?

A Yes, we do. Annually.

Q And you did examine Julian Vella in 1968, did you not, when he went aboard the ship?

A One of our physicians did. I did not personally.

Q I understand. One of your Ford physicians did.

A Yes.

Q And he was found fit for duty?

A That is correct.

Q And it was found that whatever those head injuries

were before were not really disabling in any way. Isn't that correct?

(Tr-133)

A May I refresh my mind here? 1966?

Q 1968.

A Did you say 1966?

Q No. The accident happened in 1968 and I'm asking if he had a physical examination in 1968 when he went aboard the ship. Or 1967.

A March 21, 1967, 3-11-66.

Q But 1967. Any other physical examination after March 1967, pre-sailing physical?

A There is no examination in 1968.

Q All right. And so in 1967 he was—you found that there was no disability preventing him from performing his duties as a seaman.

A In 1967 he was given a work classifications with no work restrictions, which was a clear bill of health.

Q Clear bill of health. So he did have a clear bill of health in 1967.

A That is correct.

Q So all of those things that may have happened to him before 1967 that you have testified to, he had a complete recovery of everything in that regard.

A I would assume that he was fit.

Q All right. Now, with regard to matters pertaining to the dispensary. You are saying it's open—when I say dispensary, I don't mean that. I mean the hospital out

(Tr-134)

there—it's open 24 hours. When one goes in there, he doesn't necessarily see a doctor. Isn't that true?

A If he has had a recent physical—for instance, you have had a physical within the past four months and you come in again. You wouldn't be given a complete physical and the nurse would just make a note of your last physical exam on such and such a date and she would administer the proceedings and just send you through.

Q And you are saying that if one went in and indicated that he had a head injury and he had a headache, the procedure would be—he would first see a nurse. Isn't that right?

A The nurse would screen the case, that's correct.

Q And then down the line sometime procedurally, he should see a doctor. Isn't that true?

A That is correct.

Q That's the way it should happen procedurally.

A Usually, yes.

Q All right. And you don't know for sure about all activities that take place at the hospital at all times, do you?

A I receive a shift report—

Q I understand. But you don't watch over all persons—

A It would be impossible.

Q Of course. All right.

• • •

MR. JAQUES: And I'm going to keep my bond with

(Tr-135)

the Court. That will be all for the cross-examination.

THE COURT: Any redirect?

MR. MUNDELL: One or two questions, your Honor.

MR. JAQUES: Then I may have to ask something else.

REDIRECT EXAMINATION

BY MR. MUNDELL:

Q Dr. Laderach, was the basis for your ruling out vestibular damage in your examination of June 29, 1968—

MR. JAQUES: I object here. I don't think he has said he ruled it out.

THE WITNESS: In 1968—

THE COURT: Just a minute.

MR. JAQUES: There is no testimony to the fact he ruled out—

THE COURT: He said he ruled just the opposite. I will overrule the objection.

Q (By Mr. Mundell) You may answer that.

A Would you repeat the question?

Q What was the basis for your ruling out vestibular damage in your examination of June 29, 1968?

A Mainly through the tests that I detailed for the jury: The finger to finger, the finger to nose and the Romberg

(Tr-136)

test, together with the good co-ordination of the muscular movements of the body.

Q And finally, Doctor, could you tell us on what you based your impression of the tiny nerve branch contusion that you mentioned in the report?

A A nerve branch is like an electrical wire and it does seven or eight different functions. And sometimes when there is nerve irritation, the nerve branch behaves like an electrical shock. So the word electrical feeling was used, which directed my impression toward a nerve branch as perhaps being part of what I thought was not a major problem. And that's why I prescribed the cold packs to anesthetize the area in the parietal region.

Q Were there any objective findings in respect to that tiny nerve branch contusion?

A No, there were no objective findings.

• • •

MR. MUNDELL: Thank you. That's all.

RECROSS EXAMINATION

BY MR. JAQUES:

Q But must there have been in order for a physician to show a diagnostic impression that there may have been nerve branch contusion?

A No. Many times the patient's history alone is enough to make the diagnosis.

Q Sure. And isn't it a fact, Doctor, that with regard to
(Tr-137)
neurological examinations, one may at one time, at a given time and place, show a negative testing and another time and place, without a great distance away in time, show, adopt an opposite type of response?

A I think you are pointing to the fact that many diseases are intermittent and they come and go. I can examine and have a negative impression during a period of remission and the disease flares up and a re-examination is done which may disclose positive findings. That's why repeat visits are usually necessary.

Q And so where one does have a vestibular labyrinthine disorder and where the E.N.G. shows that, is it not a fact that he may, from time to time, be able to perform like the Romberg test that you described? He might from time to time be able to perform them quite normally. Isn't that true?

A This would depend upon the degree of loss. If the loss of the vestibular function is complete, he can never

do the tests. If it is an intermittent disease, coming and going, he can do the tests in a negative fashion when he is in trouble, he may have an opposite result. An example of this would be Meniere's Disease.

Q But if he doesn't have Meniere's Disease and that's ruled out and he does have a vestibular disorder of a
(Tr-138)
labyrinthine nature which would affect balance, this would affect balance, would it not?

A Correct.

Q All right. And so at times he may be able to perform the test properly if he has a remission of the—

A If he would have a remission, he could perform them properly.

• • •

MR. JOQUES: All right.

MR. MUNDELL: Nothing further, your Honor.

THE COURT: All right.

(Witness excused.)

THE COURT: We'll be in recess then tomorrow morning until 9:30.

(Whereupon this matter was adjourned to Thursday, April 27, 1972, at 9:30 a.m.)

• • •

(Tr-26)

EDWARD RICHARD HEIL, M.D.,

being first duly sworn, was examined and testified on his oath as follows:

DIRECT EXAMINATION

BY MR. MUNDELL:

Q For the Court and to the jury, would you state your full name, please?

A Edward Richard Heil, M.D.

Q And your profession?

A Physician, otolaryngologist. Ear, nose and throat specialist.

Q Where is your office, Doctor?

(Tr-27)

A Southfield Road, Michigan.

Q Are you duly licensed to practice as a physician and surgeon in the State of Michigan?

A Yes.

Q Do you specialize, Doctor?

A Yes. In ear, nose and throat.

Q Would you tell us where you took your medical training?

A Yes. I went to Medical School at Wayne State University and I interned at Detroit Receiving Hospital and I took an ear, nose and throat residency also at Detroit Receiving Hospital.

Q And you specialize in ear, nose and throat?

A Yes, that's right.

Q And in surgery in that field also?

A That's right.

Q Have you had any other additional study or training in that field of your specialty?

A Just in the way of postgraduate courses.

Q In the local courses?

A At the University of Cincinnati and Ohio State University.

Q Are you a member of any specialty boards, Doctor?

A Yes. I'm a member of the Wayne County Medical Society, the Michigan State Medical Society, the AMA or American Medical Association, and the American Academy

of Ear, Nose and Throat and the Detroit Otolaryngological Society.

(Tr-28)

Q Do you limit your practice to ear, nose and throat, Doctor?

A Yes.

Q Are you on the staffs of any hospitals?

A Yes. Primarily Grace Hospital of Detroit, as well as Crittenton, Children's and St. Joseph's Hospital in Detroit.

Q There you engage in your specialty?

A Yes.

Q Did you have occasion to examine Julian Vella at my request?

A Yes. I originally examined Julian Vella in my office on March 20, 1972.

Q On that day, did you take a history from Mr. Vella?

A Yes.

Q Would you tell us what that was?

A Yes. At that time, Mr. Vella claimed that while he was employed on the ship S.S. McNamara, he slipped and struck the left side of his head against the fuse box and he claimed he was unconscious for a period of time after the injury. Since the injury, he claims that he has had persistent vertigo or dizziness, as well as some headaches. Mr. Vella also claimed at that time that he has had some hearing loss, particularly in the left ear, following the injury. His vertigo or dizziness is primarily postural. That is, it's

(Tr-29)

incited by movement or aggravated by movement, I should say. And he denied any appreciable ringing in the ears when I originally examined him, but he did have a complaint of an occasional headache, particularly on the left

side of his head, since the injury. He told me he was alone at the time of the incident and consequently he was unattended to. That's the essence of the history I obtained.

Q Did he say anything about working after the accident?

A No, he didn't. Apparently he had worked after the accident, but this wasn't brought about in the history.

Q After taking the history, then, Doctor, did you examine Mr. Vella?

A Yes.

Q Would you tell us what that examination consisted of?

A Well, examination essentially consisted of examination of the ears, nose and throat, with particular reference to the ears. Examination of the ears didn't reveal any significant abnormalities. That is, the ear canals and tympanic membranes appeared essentially normal. A hearing test was done also and this showed some hearing loss in both ears, primarily in the high frequency range.

Q What would that indicate to you, Doctor?

A Well, the most common cause of the high frequency hearing loss is exposure to loud noise over a period of time.

(Tr-30)

There's many other causes of this, of course. High blood pressure, hardening of the arteries and a head injury could do this also. The most common cause of this would be so-called acoustic trauma or noise-induced hearing loss.

Q Go ahead, Doctor. Did you conduct any other tests in the course of your examination?

A The only other test I did was a Colora test where we instill cold water in the ear and then determine the response of the inner ear. We look for rapid to and fro movement of the eyes. This tells us the function of the inner ear.

This is somewhat of a gross test. There are more refined tests along the same line, such as the electronystagmograph. This is somewhat more crude and not quantitative. But this test was normal as performed in my office. That is, it showed equal response in both ears.

That is the essence of the examination as to physical facts except for some tuning fork tests which were not significant or normal, I should say.

Q Following those tests performed in your office, did you feel it necessary to have some other test performed?

A Yes. With a patient with symptoms such as dizziness and headache, one test which is most important, which is the electronystagmograph, which Mr. Vella had previously but

(Tr-31)

which we thought advisable to have it repeated since it had been several years since he had the original one—

Q What does that consist of?

A Again, this is the test where cold and/or warm water is instilled in the ear and the patient's response—that is the response of the eye movement of the patient—is recorded on a graph. It's similar to a cardiogram as far as the tracing. This determines the function of the inner ear. That is, the function of the balance mechanism of the inner ear. If there is any labyrinthine damage, it is often picked up on a test of this sort or on this test.

The other test we do that is very important in evaluating any patient with dizziness is the so-called Bekesy Audiometry. This is a refined hearing test which on occasion can determine the exact source of the patient's problem. That is, whether or not it is originating from the inner ear or from the brain. So these were the two tests that were most important and both of these were done.

Q Doctor, before we go on, at that time did you have available to you an electronystagmography test that had been performed on Mr. Vella in December, 1969 or January, 1970?

A Yes, I have the report of that test.

(Tr-32)

Q Do you recall the results of that particular electronystagmography test that you reviewed?

A Yes. On that test, it showed there was some decreased vestibular response on the left ear. That is, there was some involvement of the inner ear in the left side or of the vestibular mechanism of the left ear.

Q When you had another electronystagmography test performed in March of this year, Doctor, would you tell us the results of that test?

A Yes. This is somewhat perplexing because on the repeat test, which was done on April 7, 1972, this showed there was a decreased vestibular response on the right side this time rather than on the left.

Q Was that of any medical significance to you at that time, Doctor?

A Well, not really. It was most confusing, to be honest with you. Generally speaking, a vestibular damage secondary to a head injury usually doesn't fluctuate in this manner. That's the thing that was kind of perplexing about it. But other than that, it certainly didn't help too much in the way of diagnosis or prognosis.

Q Doctor, would you tell us what is meant by a vestibular disorder?

A A vestibular disorder is a disorder involving the balancing mechanism of the inner ear. The inner ear has two basic components: The part that is concerned with

(Tr-33)

hearing — that's called the cochlea — and the vestibular system which governs a person's balance. Now, a vestibular disorder merely means there is some involvement, whether it be due to inflammation or vascular change, involving the balance mechanism of the inner ear. There are numerous things or conditions which could produce this sort of picture, but in essence it means there is some disease or involvement of the balance mechanism of the inner ear.

Q Could you tell us what causes or brings on a vestibular disorder?

A The list is infinite. I could spend all day on the list of things that could do this. Probably the most common cause of vestibular disorders that we see in a ear, nose and throat office would be labyrinthitis or Meniere's Disease. These are probable. Most common.

Now, the other fairly common causes of vestibular disorder would be — a head injury could also do this; various metabolic or systemic diseases, such as diabetes, thyroid disease, multiple sclerosis, could produce this sort of picture.

Occasionally we will see this for no obvious reason. That is, a person will present with a decreased vestibular response and we are completely in the dark as to the cause of this. Occasionally certain diseases, such as a virus

(Tr-34)

infection as you would see with the flu or a cold, could even produce a vestibular disorder. But I would say the most common cause would be so-called labyrinthitis, Meniere's Disease. And again, this could occur with these other conditions I mentioned also.

Q Do you know, Doctor, what brings on labyrinthitis?

A No. Actually, there are certain things that can do this, such as a virus infection, when the virus settles in the inner ear. This could also be due to hardening of the arteries or arteriosclerosis. It's more common in people with diabetes and high blood pressure. For the most part, labyrinthitis or Meniere's Disease, the cause of these two conditions is completely unknown.

Q Now, Doctor, in the course of your examination, was there an indication that Mr. Vella had had a hearing loss in previous years?

A Well, in looking over the hearing tests which were done at Ford Clinic, they show that he did have some hearing loss previously. Most of the hearing loss was primarily again in the high frequency range.

Q Was that essentially what you found on your examination this time?

A Yes. The tests we did essentially showed the same thing. There was a high frequency hearing loss. It was somewhat more pronounced on his most recent tests than

(Tr-35)

previously, but for the most part, the hearing test was fairly identical.

Q It has been testified to in this case by Dr. Neilsen that there was no objective evidence of any trauma to Mr. Vella. Dr. Berke also testified to this, as did Dr. Laderach from the Ford Motor Hospital who examined Mr. Vella the day he left the ship; and this was some three months after the accident. Would that information or was that information considered by you in arriving at your diagnosis in this case?

A Well, it's a little hard to answer that question yes or no. If there was some objective evidence of damage, such as a neurological deficit, this certainly would be more consistent with the fact that Mr. Vella's present symptoms are related to the head injury. But as it stands, I don't think that their negative findings helped me too much as far as trying to assess a cause or ideology or prognosis of his vestibular problem.

Q The same doctors, Dr. Heil, with the exception of Dr. Berke who found a positive Romberg test, found no objective neurological symptoms in Mr. Vella. Of what medical significance would that be to you in your determination?

A Well, probably not too much, really. The Romberg is a test to determine whether or not the cerebellum, which

(Tr-36)

is a part of the brain, is involved. And again, from my standpoint, this really would not be of too much significance. The test is somewhat crude. I might say, and it's not a test in my estimation would be that important, really.

Q After your examination and the tests that you had performed, did you come to a diagnosis and would you tell us what, in your opinion, was troubling Mr. Vella?

A Well, again, that's extremely hard to do because Mr. Vella's symptoms, mainly vertigo, are a subjective finding and there really were no subjective findings that we could pinpoint except for a decreased labyrinthine response which fluctuated from the left side on the first test to the right side on the second test. As a result of this, it's very difficult to make a definitive diagnosis as to Mr. Vella's condition here. I'm somewhat at a loss to

come up with a specific diagnosis in this matter. Again, as I mentioned, Mr. Vella's primary symptom of vertigo is a subjective symptom which cannot be measured and certainly, the cause of this problem is not clear.

Q The results of the electronystagmograph test, however, indicate there is a vestibular disorder problem here?

A That's correct.

Q Is there treatment available for that disorder? Can it be treated toward a cure?

(Tr-37)

A No, not really. Treatment is primarily symptomatic for this condition. That is, people with a vestibular disorder are apt to have intermittent episodes of dizziness which, on occasion, are somewhat more severe. Treatment is limited to those times when the patient is particularly dizzy. They can obtain some symptomatic relief with medication. Other than that, there is no specific cure or treatment.

Q Now, Doctor, if a vestibular disorder or damage resulted from a blow to the head, what would the symptoms be and how severe would they be following such a blow?

A Well, the main symptoms, of course, would be dizziness and headache, possibly some visual disturbance such as double vision, blurred vision and possibly even some nausea with or without vomiting. Those are generally the symptoms that occur after a head injury of any degree of severity.

Q Where vestibular damage occurred, what would the severity of those symptoms be in relation to a man say continuing to be able to work?

A Well, the best way I can answer that is in general, a patient who sustains a head injury severe enough to produce labyrinthine damage as determined by the electronystagmograph, the head injury would have to be quite a severe head injury in order to produce this picture. And

(Tr-38)

again, the symptoms I referred to before would mainly be dizziness, headache and possible nausea and vomiting and possibly some visual disturbances such as blurred or double vision. But mainly the dizziness and headache.

Q Do individuals continue to work that might have a vestibular problem then?

A Well, that's hard to say. It depends on the severity of the injury, the type of work he's doing. But in general, if a patient sustained a head injury severe enough to produce a labyrinthine disorder, it wouldn't seem too likely he would be able to work or continue to work because it takes a fairly severe blow on the head to produce decreased vestibular function.

Q What then, Doctor, was your final conclusion after your examination of Mr. Vella?

A Well, the conclusion was that this man has a vestibular disorder which apparently is fluctuating. That is, it was originally on the left side and more recently has shifted to the right side. The cause for this I have absolutely no idea whatsoever. As far as a definitive diagnosis, we have absolutely no grounds or I have not enough evidence really to produce any dfinitive diagnosis in this matter. By that I mean I can certainly not say to any degree of certainty this man has a specific disease entity which I have been able to find.

(Tr-39)

Q Just one final point then, Doctor, and I believe you mentioned this before. But the treatment that is afforded or is available for persons suffering from a vestibular disorder is merely treatment —

MR. JAQUES: Just a moment.

This is crucial. I believe he ought to not lead the witness. He may ask the questions but not lead the witness, your Honor.

MR. MUNDELL: I'll rephrase the question, your Honor.

THE COURT: All right.

Q (By Mr. Mundell) Would you tell us again, Doctor, the treatment, if any, that is available for a vestibular disorder and if it is such that it would work to effect a cure?

A Well, in general, the only treatment is so-called symptomatic treatment. That is, we can control or alleviate the symptoms related to a vestibular disorder, but there is no definitive cure for a vestibular disorder per se. In other words, if the patient is having episodes where the dizziness is becoming quite severe, there are certain medications which we can give which will help; that is, which will alleviate the dizziness.

Q This is to ease —

A To ease the dizziness, right. We're treating the symptom, not the disease itself. There is no specific cure

(Tr-40)

for a decreased labyrinthine function, but there is a treatment or cure, I should say, for the dizziness itself.

MR. MUNDELL: Thank you, Doctor.

You may cross-examine.

THE COURT: Gentlemen, will you approach the bench for a moment, please?

(Whereupon an off the record discussion was had at the bench between the Court and counsel.)

THE COURT: Well, I guess we have reached the lunch hour. We will recess then until 2:00 o'clock.

(Luncheon recess.)

(Jury enters courtroom.)

THE COURT: All right, Mr. Jaques.

MR. JAQUES: Thank you, your Honor.

CROSS-EXAMINATION

BY MR. JAQUES:

Q Good afternoon, Doctor.

A How are you?

Q The scientific name of ear specialty is maybe one of the hardest to pronounce. What is that again?

A Otolaryngology.

Q And just in short, you do classify yourself as an ear,

(Tr-41)

nose and throat specialist?

A Yes, that's right.

Q And I'm impressed with the fact that you are Board certified, aren't you?

A Yes.

Q I would congratulate you for that.

A Thank you.

Q I do just have a few questions here if we could go into some of the matters you testified to and also with regard to examination of Mr. Vella and if we could just get perhaps more clarity as to what these matters are. And I will ask you: When did you first agree to see Mr. Vella?

A It probably was one week prior to the time I saw him. So that would be somewhere around the middle of March.

Q Of this year?

A Of this year.

Q And at that time, the purpose of examination was related to you?

A Yes.

Q And that being, of course, that you were to examine him because of a pending litigation where the matter was scheduled to go to trial?

A Yes.

Q And you did reduce to writing a report of sorts, didn't you?

(Tr-42)

A Yes.

Q And that report was dated April 12, 1972?

A Yes.

Q And then you had also arranged to have Mr. Vella come to your office in March of — what was that date?

A March 20 of this year.

Q He came to your office in Southfield. Is that correct?

A Yes.

Q And then after that, you had him go to another place. Isn't that correct?

A Yes.

Q And that was to further provide data for the complete examination that you were to conduct?

A Yes.

Q And you do, however, have some kind of testing apparatus in your office, in your own office, don't you?

A Yes.

Q And here you did perform some kind of — well, I want to say audiometric, but that probably wouldn't be right. But some kind of a hearing test. Isn't that correct?

A Yes

Q What is the name of that hearing test?

A Well, it's called an audiogram or audiometric examination.

Q I had part of it right. And that audiogram, did you

(Tr-43)

perform that yourself?

A No. My technician performed it.

Q But you caused it to be performed. And I assume then that there was a recording of the information?

A Yes.

Q And then based on that audiogram or the hearing test itself, you were able to come up with some idea of the hearing of Mr. Vella as based on some kind of a normal circumstance of hearing?

A Well, we have — essentially we performed the test and had it recorded on a chart, yes.

Q And that was with both ears?

A Both ears.

Q And then you found — what was the result of the hearing test?

A The result was that Mr. Vella had a hearing loss in both ears, mainly in the high frequency range.

Q But more in one ear than another?

A In my test, it showed it was somewhat more pronounced in the left ear.

Q And more pronounced in the left ear. Now, looking at that in and of itself, the hearing loss, were you able to make a diagnosis with regard to the kind of hearing loss

it was? Do you understand the question?

A Yes. Yes, we determined this was a so-called nerve

(Tr-44)

hearing loss, primarily in the high tones. And I might say that on further testing which was done on my recommendation at Wayne Speech and Hearing Clinic, that the hearing was essentially identical in both ears.

Q But based on the testing you conducted or caused to be conducted in your office, you made a determination of two factors. Isn't that correct? First of all — let's say three factors — first of all, that there was a dimunition or reduction of hearing loss in both ears.

A Yes.

Q And then, that there was more of a hearing loss in the left ear than the right ear.

A That's correct.

Q And that the hearing loss was determined by you to have been a nerve damage loss. Is that correct?

A Yes.

Q And so if we could just try to clarify some terms here. Sometimes, you know, those of us who are not doctors have trouble using the terms as the doctors use them. But I'll ask you this: Would you agree with me, Doctor, that when we use the word diagnosis, that really what is meant here is that well, like pertaining to a doctor, a physician makes a determination of or an opinion as to what the exact disorder is.

A Yes.

(Tr-45)

Q Wouldn't that be true?

A Yes.

Q Using that perhaps oversimplified test, but at least that meaning of diagnosis, would it not be fair then, Doctor, that you did diagnose the hearing loss as being a nerve-type hearing loss?

A Yes.

Q All right, thank you. And now, insofar as the other tests were concerned—and thank you for alluding to it—you said that there was another similar test or perhaps identical test taken later at the Wayne Clinic.

A Yes.

Q And you found that that was a little bit different.

A Yes. The findings were somewhat different in that the hearing loss was identical in both ears. That is, the degree of hearing loss was exactly the same in both ears. And again, the hearing loss only affected the high frequency range and not the speaking frequencies.

Q And also, at the time that you conducted or caused to be conducted the hearing examination in your office, you had records from Ford Clinic out there where there had been an audiogram taken of the patient back in 1961.

A Yes.

Q And you were able also to make a comparison of that reading of the audiogram and the reading that you had with

(Tr-46)

the one that you caused to be conducted in your office, didn't you?

A Yes, essentially.

Q Would you tell us, then: What was that comparison?

A Well, as I mentioned before, the test that he had back in 1961 at Ford also showed that he had a high frequency nerve hearing loss in both ears.

Q But the actual readings—maybe we could hold that up a little bit. If we could just see what we're talking about, those readings.

A Yes. And perhaps the jury can see.

This is what you mean by the readings. Isn't that correct? The one on the right.

A Right.

Q More like a chart or graph.

Here, you may have it back.

And so the test taken in 1961 and the test that you took with regard to the differential between the left ear and the right ear, was that different or the same or comparable?

A Yes. The hearing loss on the most recent test in March 1972 showed that the hearing loss on the high tones was slightly worse than it was back in 1961, which itself is not too surprising. As we were discussing before, the most common cause of a high frequency neuro-sensory hearing

(Tr-47)

loss is repeated exposure to loud noise over a period of time. There has actually been 11 years between these two tests. It would be most unusual if there was no difference in the hearing in an 11-year span.

Q But the relative difference between the left ear and the right ear, as you found it in your testing, was comparable to the relative difference between the left ear and the right ear that was performed in 1961. Isn't that correct?

A It was very similar.

Q Very similar. Then you are saying that the hearing examination that conducted just a few days over there at the Wayne Clinic which you asked to be conducted—but I take it that you weren't there when it was conducted.

A No.

Q That was a different kind of reading. Isn't that correct?

A Yes.

Q All right. And so you construed that to be a bit puzzling. Isn't that right?

A Not really. I would be inclined to accept the report of the Wayne University Speech and Hearing Clinic. The people performing the tests over there are Phd's. in audiometry and I would have a little more faith in their results than in our office. The tests we do in our office are for gross scanning and cursory type of testing. I would have to ac-

(Tr-48)

cept their findings in lieu of mine.

Q So you would accept theirs over yours?

A Yes.

Q Even though it was different, you would accept it without being puzzled or confused in this regard?

A I would have to accept their findings.

Q You would accept them. But would you accept it carte blanche without reservation?

A Pretty much so.

Q And then if we could go one step further with regard to the hearing loss shown at the medical clinic of Wayne State University, what medical significance attaches to that?

A Medical significance in regard to what?

Q Well, gee, I just asked what medical significance. In other words, was the hearing test normal at the clinic?

A No, no. It showed that there was a high frequency loss in both ears.

Q And I'll ask you: Did that change your diagnostic impression of the type of hearing loss?

A No, not at all.

Q It would be the same?

A Yes.

Q A nerve-type damage?

A That's right.

(Tr-49)

Q And insofar as the other—well, you had more than one test conducted at Wayne, didn't you?

A Well, there were several parts of the hearing test battery that was done, that's correct. He had somewhat of a more sophisticated test done because Bekesy Audometry, which really didn't help us too much in our diagnosis, this is a very, very specialized type of test which is only done in a few places in the city. It can determine whether or not a person's problem is related to his hearing and balance, whether it originates in the inner ear or from the brain. And this test did not prove this one way or the other. This is a Bekesy Audometry, which we referred to before.

Q It didn't prove one way or another but is designed to prove one way or another. Is that correct?

A That's the purpose of the test, yes. In this case, it didn't help us one bit.

Q And what kind of reading did you get from the test?

A The test was read as a so-called Type one Bekesy reading. And actually, all this indicates—excuse me. Type one in the right ear, Type two in the left ear. Type one and Type two readings both are considered essentially normal. What this means is that the lesion cannot be incriminated or cannot be thought to be in the inner ear or in the central nervous system.

(Tr-50)

Maybe I'm not too clear. Let me explain that a little further. Very often, people will have a condition such as inflammation of the inner ear, such as Meniere's Disease. This test will show on the reading fairly conclusively that the patient has that condition on the basis of the audiometric finding. This also applies to other conditions in the brain, such as a small tumor which originates in the inner ear; and this is called an acoustic neuroma. The purpose of these tests was to try to determine whether or not the patient has either of these two conditions. And according to the reading which we received from Wayne, we were not able to confirm the diagnosis of these two conditions. The test was done primarily to exclude these two conditions.

Q Doctor, just so that we can clarify this: Do you recall that I did have an opportunity to talk to you? It was really a deposition that we took in the law offices of Foster, Meadows and Ballard on the 11th day of April. In fact, I think this trial had just commenced that morning.

A Yes.

Q On the 11th day of April, 1972. And you do recall that we did have that deposition?

A Yes.

Q I'll ask you this: Do you remember this question? The question was put on Page 27 with reference to these

(Tr-51)

tests that you just described. And the question put to you was:

"Did you rule out tumor?"

And the answer:

"Yes, we ruled out tumor. And we fairly well ruled out Meniere's Disease. Meniere's Disease is

one specific form of dizziness which originates from the inner ear."

Do you remember that question and do you remember that answer?

A Yes.

Q And so I'll just ask you now, now that we are before the jury: It would appear to me that the answer given in response to the question at the time of deposition would be just a little different from the answer given here if not totally the opposite. So I'll ask you: Do you rule out tumor?

A On the basis of the test, yes. The specific tumor we were talking about was this acoustic neuroma. We fairly well ruled that out.

Q So this test was and is designed to make a determination as to whether or not there is a tumor existing. Isn't that correct?

A Yes.

Q So in that sense, the test was useful in ruling out the

(Tr-52)

possibility. Is that correct?

A Right.

Q Now, the same way with this Meniere's Disease. I will again quote, in response to the question:

"And we have fairly well ruled out Meniere's Disease."

I will ask you now: Did that test, based on the findings that were recorded, did that also fairly well rule out Meniere's Disease?

A Yes, it did.

Q All right. And so insofar as the test is concerned, Doctor—well, just go back so I can write it down. What is that sophisticated test you said you used?

A It's Bekesy, B-e-k-e-s-y.

Q Audometry. So I'll put this question to you again: Did the Bekesy Audometry test assist you in ruling out tumor and Meniere's Disease?

A Yes. You just mentioned there was some discrepancy between my statements; between my deposition and what I said earlier. I would like that clarified. I didn't think there was any discrepancy. I mentioned earlier we had fairly well ruled out Meniere's Disease and I mentioned that also in the deposition. What discrepancy are you referring to? I am at a little loss.

Q I think it's cleared up. I think that the questions that

(Tr-53)

I have put to you have pretty well cleared it up now. I think it was somewhat unclear a little earlier, in the beginning of our questioning. But I think it's cleared up now.

First of all, were you able then to arrive at a consideration of the entire problem after you yourself had given a physical examination of the patient and after you had caused an audiogram to be taken in your office and after you had caused the audiogram to be taken in the Wayne State Medical Clinic, the audiometric tests to be taken, the Bekesy Audometry test to be taken? Were you then able to consider the overall picture or did you then need more tests?

A No. The only tests that we thought were essential at that time were the audiometric testing which was done and the repeat on the electronystagmogram.

Q That would be called the ENG, the electronystagmogram?

A Right.

Q So if you don't mind, I'll call that ENG. It's a lot

easier. Was that ENG done right there where they did the audiometric tests?

A No. It was done in a different building.

Q Where was that done?

A The ENG is done at Harper Hospital and the Bekesy Audometry was done at the Wayne State University Speech and Hearing Clinic.

(Tr-54)

Q The ENG was done at Harper Hospital later. Is that correct? After the audometric tests were done?

A No. I think the ENG was done first and then the Bekesy Audometry. I don't think it's too significant. They were both done within a fairly short span of time.

Q But irrespective, they were done at your request?

A Yes.

Q And then you did also, did you not, have benefit of the ENG that was performed in 1969?

A Yes, I have a copy of that.

Q And that ENG that was performed in 1969, it's in the record so you can refer to it. It's perfectly all right. It's one of the exhibits in our lawsuit. That ENG showed a vestibular difficulty, is that correct?

A Yes. It showed a vestibular deficit on the left side at that time.

Q Now, going into that vestibular deficit—was that the word used after vestibular in that instance or another word?

A No. I think they used the term decreased vestibular response, which is essentially the same thing.

Q Did they use the word labryrinthine?

A Let's see if they did or not. There's several ways you can phrase this thing, which all means the same thing.

(Tr-55)

Q All right. So the vestibular deficit and vestibular labryinthine all mean the same thing?

A Yes.

Q Which means some problem in the mechanism of the balance. Is that correct?

A Yes. There is some problem or disease process in the vestibular mechanism of the inner ear, that's correct.

Q And so based on the tests that were given to you or rendered at your request and based on your examination, you were able to have come up with a diagnosis of a hearing loss of a nerve root type. Isn't that correct? You said that before, but isn't—

A Nerve-type hearing loss, yes.

Q And then you were also able to come up with a diagnosis based on the ENG of a vestibular disorder. Isn't that correct?

A Yes.

Q And then you were able to come up with a diagnosis that the patient was free from head tumor. Isn't that correct?

A Of the specific type that I referred to, acoustic neuroma. I'm not saying head tumor in general, but the specific type we are looking for.

Q Well, be specific then. Acoustic neuroma, head tumor; he was free from that?

A Yes.

(Tr-56)

Q And then you were able to come up with a diagnosis that he was—based on reasonable medical certainty. I assume you can't be absolutely positive on anything medically. Isn't that correct?

A That's pretty much true.

Q So based on reasonable medical certainty, you were able to come up with a diagnosis that the patient was free from Meniere's Disease.

A Yes.

Q And so you also were able to gain from the patient himself facts pertaining to a trauma that occurred in 1968. Isn't that correct?

A Yes.

Q And one of the causes of a vestibular disorder or this inner ear problem is trauma. Isn't that a fact?

A Yes, that is one of the causes.

Q Yes. And were you also incidentally given the medical records from Ford Clinic showing that in 1967, the patient was given a complete and thorough physical examination and that he was free from any medical defect and that he was, to use the words of the doctor who gave it, the Ford doctor, he was given a clean bill of health? Were you furnished that information at the time?

A I don't think so, no.

Q Well, all right. And so would you just, for the purposes of this cross-examination, then accept that as fact

(Tr-57)

because this is in fact in the record? There are causes, I take it, of a—there are causes of a vestibular nature other than trauma. Is that correct?

A Yes, there's quite a few other causes for—

Q Yes.

A Would you like me to elaborate on that?

Q No. I'll ask you this question: Are there not just three categories?

A Well, I don't know what you mean. Three categories of what?

Q If I can help you to refresh your memory, back when we took this deposition on the 11th of April, the question on Page 22—and perhaps this will refresh your memory was:

> "Then you have looked on this vestibular problem with Mr. Vella as being organic, certainly?
>
> "A I'm not able at all to say with any certainty. I don't know.
>
> "Q But if it is not organic, what is it?
>
> "A Well, it is organic or—well, there are three categories that it could be, which I have no idea what it could be."

(Tr-58)

Do you remember that answer to that or would that refresh you sufficiently so that now you can tell us what the categories are?

A If I can just browse through here—I still don't quite know—three categories of what do you mean?

Q At this point, I'm only asking if this does refresh your memory.

A No, it doesn't. If you could tell me what page this is on in the deposition, maybe it could refresh me a little more.

Q All right.

A Oh, I think I have an idea what you mean now. I think we were discussing when a patient presents with various symptoms in the office, these are not always on an organic basis. That is, not necessarily are these symptoms due to definite disease entity or organic disease. These three categories we encounter are: First of all, people with an actual organic disease. Of course, this can and does produce symptoms. The other category is people who have hysterical or emotion symptoms. I might tell you

right now these are true symptoms but they are on an emotional basis. This is very, very common. The third category is people that, for one reason or another, are so-called malingerers and actually have no symptoms whatsoever. These are the three basic types of people we encounter.

(Tr-59)

Q So one is organic and the other is psychological or emotional.

A Right.

Q And the other is an absence altogether.

A That's right.

Q In other words, which in effect would not even be a vestibular problem at all, would it?

A That's right.

Q So reduced down, is it not a fact, Doctor, there are two categories of actual vestibular disorders?

A I think we are getting kind of far out. A vestibular disorder—can you clarify that a little bit? I don't know quite what you want.

Q I'm just going back. And the question is, on Page 22:

"Then you have looked on this vestibular problem with Mr. Vella as being organic?"

And then you say that you are not certain. Then the question is that if it is not, what is it? And then you say:

"Well, there are three possibilities: Organic, psychological or non-existent."

So I come back and say: If it is non-existent, certainly it is not vestibular, is it?

A No, that's correct.

(Tr-60)

Q So you are really saying in effect there are two categories of vestibular disorder. Isn't that correct? One is organic and the other is psychological. Isn't that correct?

A That's correct.

Q Now, with regard to Mr. Vella, however, would you say that his is organic?

A I really don't know that. And we really can't say with any certainty on the basis of the ENG findings that the symptoms are organic. The ENG findings in themselves do not correlate with disease symptoms necessarily. What I mean by that is very often people will exhibit a vestibular labyrinthine disorder on an ENG and still be without dizziness or without any other symptoms. So it would be impossible for me to say with any definite certainty whether or not it is organic.

Q Fine, But didn't we agree a while ago that in medicine you don't say with definite, absolute certainty as to things but you speak in terms of reasonable certainty? Isn't that right?

A Yes.

Q All right. Now, I will ask you if you recall making the statement on Page 29 in the deposition, and I quote:

"The fact that Mr. Vella does have a labyrinthine abnormality on the ENG or electronystagmography

(Tr-61)

indicates that in all probability, there is something organic that is producing these symptoms."

Do you remember saying that?

A. Yes.

Q All right. So is it not a fact then, Doctor, that you mean to tell this court and this jury that in all probability,

based on the ENG and based on the test, that he does have an organic producing symptom of his vestibular difficulty?

A Yes. But again, it would be hard to say that with any definite certainty, that it is. It is probable. It could very well be. But it it impossible to say with any certainty that it is because I think I mentioned—

Q Let's stop here because this is terribly confusing. Let's start with probabilities now. When we speak in terms of probabilities, we go beyond just mere possibility, don't we?

A Yes.

Q Sometimes our meaning of words kind of causes a lack of communication. So that's really all I'm trying to do here. And when you said that in all probability the vestibular problem was organic and it produced this symptom and it was an organic derivation, the symptom was of an organic derivation—

(Tr-62)

MR. MUNDELL: I would object, if the Court please. Mr. Jaques is taking this question out of context; and unless the rest of it is put in it makes no sense the way it is in the deposition and the way Mr. Jaques has read it.

MR. JAQUES: All right. You may work this in.

He may work it in. I'm taking it step by step. But I think the objection should be overruled.

THE COURT: Since I don't have the benefit — go ahead. I'll overrule it and see where we go.

MR. JAQUES: Thank you.

Q (By Mr. Jaques) So you are saying that it is probable that it is organic. Isn't that true?

A Yes, that's right.

Q So today you are saying even though it is probable

you are not going to say it is absolutely — it's an absolute certainty to be organic. Isn't that right?

A Yes, that's right.

Q We understand. In other words, based on reasonable medical certainty, in terms of probabilities, the origin is organic.

A It could be.

Q All right.

A I have no way of telling for sure whether it is or not.

(Tr-63)

There is no possible way to determine this and —

Q This is the thing: I want you to go either one way or the other. Is it probable or improbable that it is organic?

A It's possible and/or probable. It's —

Q Don't you make a distinction between probable and possible?

A No. It is possible that it could be and I'll even go as far as to say it's very probable also.

Q All right. And it would be your testimony that there is no question that head injuries can cause dizziness. Isn't that true? Just answer.

A Oh, yes, a head injury can cause dizziness.

Q And when we speak in terms of trauma, we mean a blow to the head of some kind. I mean a blow, a hitting of some kind. Right?

A Yes.

Q And you would also say that head injury could cause postconcussion vertigo. This could cause the vestibular difficulty. Isn't that correct?

A That's one of the causes.

Q You mentioned this morning that there was some-

thing pertaining to like a — I think you said diabetes could cause some kind of dizziness.

A Yes. There is quite a list that can. If you want to go through this real briefly, I can tell you some of the

(Tr-64)

things that can do this.

Q Suffice to say that things within the symptom other than a trauma could cause the dizziness. Is that correct?

A Yes. There's many, many things that can.

Q Right. So we have dizziness. And is it not a fact that we have dizziness that persons experience where you may have dizziness without the fear of or without the sensation of falling? Isn't that correct?

A Well, in most forms of dizziness, the people do experience a sensation of falling or the room turning or themselves turning. There is some sense of movement.

Q In most forms?

A Yes.

Q But there are forms perhaps when one may have dizziness and still not have the sensation of falling.

A Yes, that's correct.

Q And when one speaks in terms of vestibular disorder, where there is a vestibular disorder in and of itself, the vestibular disorder does not always mean that you are going to have dizziness, does it?

A That's correct.

Q And so that dizziness can come and it can go. Isn't that correct?

A Yes.

Q And that vestibular problem, insofar as dizziness is

(Tr-65)

concerned, really you would have to have the dizziness coupled with the vestibular difficulty in order really for

there to be a disability. Isn't that correct?

A No. That statement doesn't make sense to me at all. Would you try to rephrase that? You say the dizziness coupled with the vestibular problem would what?

Q I'm saying vestibular deficiency—isn't that what you said—or vestibular difficulty—deficit. I think that's the word you used. A vestibular deficit. That may from time to time vary. Isn't that correct? Insofar as disability is concerned.

A Well, it could, yes. People with dizziness, very often their dizziness would be more severe on certain occasions, yes.

Q All right. But insofar as the treatment is concerned, I think you said this morning that you can treat the symptoms. Isn't that right?

A Yes. You can treat the symptoms when they become severe enough to treat. Very often, I say there are times when a person has more trouble and is much more dizzy and you can treat the symptoms when this should occur.

Q But insofar as the symptoms being—well, of course, the vestibular difficulty, there is no question here Mr. Vella has a vestibular difficulty. Isn't that correct?

A Yes.

(Tr-66)

Q So insofar as the dizziness is concerned, this dizziness may be treated. Isn't that correct?

A The dizziness can be treated at the time when his dizziness is severe enough to warrant treatment, yes.

Q But dizziness coupled with fear of falling, now, what would you comment with regard to that?

A Well, most people that do have a problem with balance, they do experience some fear as to exactly when the

episodes of dizziness are going to occur and they are somewhat fearful, which is true with almost every episode of of dizziness. The fear is usually an anticipation of the symptoms recurring.

Q Yes. So here's where you have a circumstance of dizziness where you have a vestibular problem; where you do have dizziness and where you have a fear of falling. Now, do you have an opinion as to whether or not there would be a disability in performing duties aboard a ship like down in the engine room?

A Well, again, this all depends strictly on the degree of dizziness that the patient is having, exactly what type of movements the job involves; and it would be impossible for me to say with any certainty. This varies with any individual and his problem and the job he has to do.

Q I understand Doctor. I'm talking now in terms of— and perhaps we might directly allude to Mr. Vella, where he

(Tr-67)

does and it is shown that he has a vestibular problem and it is shown—by the way, there is no test to show dizziness, is there? You don't have a test showing dizziness, do you?

A No, not really.

Q So where the patient has indicated that he does have dizziness and that he does have fear of falling—and this, in and of itself, certainly is consistent with a vestibular problem. Isn't that true?

A No, not actually. Dizziness—

Q Is it consistent with a dizziness problem?

A Dizziness can occur from other than vestibular problem—

Q Please understand the question. Given a circumstance

of a vestibular labyrinthine disorder, is it not true that dizziness is consistent with this problem?

A Dizziness is part of the symptom complex, that's right.

Q Fine. And fear of falling is also a part of the whole syndrome. Isn't that correct?

A Yes. Most people with dizziness have some fear of falling.

Q So where you have a circumstance of vestibular problem with dizziness and fear of falling, is it not true that there would be disability in performing work activities on a moving ship with moving parts in the engine room of a nature which would cause him to be unfit for that kind of work?

(Tr-68)

A The only way I can answer that is in general. People that have a problem of balance or dizziness would have more problems like on a ship where there is a constant pitching motion, yes.

Q So the answer is yes. Isn't that correct?

A Yes.

And as a matter of fact, Doctor, is it not within the spectrum of — well, I'll use another word — where one has become traumatized and where a vestibular problem arises after he is traumatized, is it not within the general chain of events that he would subsequently realize intermittent dizziness and then eventually have visited upon him the fear, the utter fear, of his life being endangered because of falling?

A Are you trying to say right after the injury?

Q No. I'm just saying not necessarily right after, but a period of time. In other words, is it not a fact that this can certainly be a progressive stage?

A The fear of falling can, yes.

MR. JAQUES: Thank you, Doctor.

REDIRECT EXAMINATION

BY MR. MUNDELL:

Q Would you just tell us, Doctor: You alluded to the point, when Mr. Jaques asked you about the question of dizziness, you said you could tell us briefly the causes for

(Tr-69)

dizziness. Would you do that for us, please?

A Yes. Very common causes are primary diseases affecting the inner ear, such as Meniere's Disease. There are many other diseases in the same category, similar but not quite the same, such as labyrinthitis, pseudo-Meniere's Disease and many of these other inner ear problems where the causes are not definitely known. Other causes are certain viruses, such as flu. An upper respiratory infection can on occasion affect the inner ear and cause disfunction. Other causes are certain drugs having affinity for destroying vestibular function. Head injury can do it also. Another broad category of disease that can produce dizziness is so-called metabolic diabetes. Thyroid deficiency has been known to do this. Hardening of the arteries and, in elderly people, impaired circulation to the brain which is again part of the hardening of the arteries syndrome and can also do this. This is not a complete list, by any means, but it covers 90 percent of the conditions which can cause a vestibular deficit.

Q Mr. Jaques talked to you at some lengths about ruling out the tumor and ruling out Meniere's Disease by use of the Bekesy Audometry.

A Yes. I think we fairly well ruled these two out.

Q But these others you mentioned, have they been ruled out by any test?

(Tr-70)

A They haven't. As a matter of fact, the thing was extremely puzzling in this case, as we mentioned before. The original ENG showed Mr. Vella had a vestibular deficit on the left side. This month, a repeat test showed the vestibular deficit was on the right side. It's fairly hard or difficult to correlate — for me to correlate the vacillating or switching response on the test like this to head injury. It would seem a head injury would produce a vestibular deficit; but you wouldn't expect it to change and then appear on the other side. The last ENG was done, in fact, along the same line that —

MR. JAQUES: I will object. I think there is no question.

MR. MUNDELL: Go ahead, Doctor.

THE COURT: What is the objection?

MR. JAQUES: There is no question put. He is narrating without a question.

MR. MUNDELL: The doctor is just completing —

THE COURT: Go ahead, Mr. Mundell.

Q (By Mr. Mundell) Go ahead, Doctor.

A On the last ENG, apparently Dr. Ben, who is the professor who runs the ENG test, suggested we do some tests such as thyroid function studies causing vestibular deficit.

MR. JAQUES: I object. This is hearsay, what some-

(Tr-71)

body said or suggested outside. This is purely hearsay.

MR. MUNDELL: I believe this is on the report from Dr. Ben.

THE WITNESS: If I could read this here —

THE COURT: If it is on the report, I will overrule the objection.

Q (By Mr. Mundell) Go ahead, Doctor.

A Let me see if it's on the report.

No, that was from a verbal or from a conversation. However, he did suggest we repeat the testing.

MR. JAQUES: May I have a ruling?

THE COURT: A ruling on what?

MR. JAQUES: I have an objection to bringing in utterances of someone outside this — it's hearsay. It's garden variety.

Q (By Mr. Mundell) Did you talk to Dr. Ben yourself?

A No, I didn't talk to Dr. Ben. I talked to one of his associates.

THE COURT: I will have to sustain the objection.

THE WITNESS: I might say, along the same line, if there is —

(Tr-72)

THE COURT: Doctor —

THE WITNESS: Oh, I'm sorry, yes.

Q (By Mr. Mundell) On the question of the head trauma that Mr. Jaques has inquired about, Doctor, the severity of it, would you tell this court and jury of the nature or severity of a blow that would bring about a condition wherein a man would have a vestibular deficit as represented here?

A Well, vestibular damage can definitely occur with a head injury. This is well known. And again, basically I do ear, nose and throat and don't handle people with head injuries that much. But I do know that in order to sustain vestibular damage from a head injury, that would require a fairly severe blow.

MR. JAQUES: I object. There has been an improper foundation laid as to his ability to testify in this regard.

And certainly, by his utterances, he admits lack of expertise insofar as response to the question is concerned.

THE COURT: He is a doctor; and although he has been qualified as an expert on ear, nose and throat, the opinion can be taken and its weight given it by the jury. I will overrule the objection.

(By Mr. Mundell) Go ahead, Doctor.

A I didn't mean to imply I have no experience with

(Tr-73)

people with head injuries. I certainly do. But again, it is definitely known in order to sustain labyrinthine damage from a head injury, this does require severe head injury. It is inconceivable that a little bump on the head or a minor trauma could produce a vestibular damage. It would require a fairly severe head injury.

Q What would the symptoms be immediately following such?

A Well, generally, after the head injury, the main symptoms, assuming the patient is not unconscious, would be severe headache, dizziness, marked —

MR. JAQUES: I will object to this, your Honor. This is not within the scope of proper redirect. This was not brought out in cross-examination.

MR. MUNDELL: If the Court please, he went into the question of trauma and that's what we are talking about.

THE COURT: I overrule the objection.

Q (By Mr. Mundell) Go ahead, Doctor.

A Well, as I say, generally these are the symptoms that usually would occur after a severe injury. The patient, if not unconscious, would be very weak, lethargic, possibly nauseated, have headache and dizziness. These are the cardinal symptoms of a severe head injury.

Generally, after a head injury, the symptoms are most severe immediately after the injury. There is a few ex-
(Tr-74)
ceptions to this. Assuming the patient has a severe injury which resulted in a small blood clot beneath the lining of the brain, this is called a subdural hematoma. Under these circumstances, the dizziness could progressively get worse up to a point until surgery is performed. That's the one circumstance where the dizziness could be progressively worse after a head injury. But generally, the most acute time—that is, the time of the most acute symptoms—would be immediately after the injury. And then as time goes on, one of two things would happen. The symptoms would either gradually subside or get better or it would stay the same.

MR. MUNDELL: Thank you, Doctor.

RECROSS EXAMINATION

BY MR. JAQUES:

Q Doctor, in the history that you took of the patient, you indicated that he had suffered a—I think you said that he struck his head.

A Yes.

Q On the fuse box. Is that correct?

A Yes. On the left side of his head.

Q Was any more information by the patient given to you with regard to the trauma itself?

A Yes. The patient indicated he was unconscious for a period of time. The exact period of time wasn't too certain,
(Tr-75)
but he claimed he was unconscious for a period of time.

Q Any other details with regard to the circumstances of the blow, the trauma?

A No. That's essentially it.

Q So you don't know, do you, as a matter of fact, exactly whether it was a hard blow, a soft blow or a blow of extreme severity or lack of severity, do you?

A No, I don't.

Q And so when you make mention of a trauma causing this vestibular difficulty, all you say is that it would have to be a, generally speaking, trauma of some magnitude. Isn't that correct?

A Yes. A fairly severe head injury.

Q And based on your expertise as a physician—and I take it, Doctor, you—well, I happen to know as a fact that you certainly have to go through high school and pre-med in order to go to medical school; and moreover, that you have to have a certain kind of academic background in order to get into medical school. Isn't that true?

A Yes.

Q Sure. And included within that curriculum is the study of certain kinds of sciences, including physics. Isn't that right?

A Yes.

(Tr-76)

Q And rather than go a great deal into the various kinds of courses, suffice to say that you are aware of certain factors with regard to trauma. Isn't that true?

A Oh, some, yes.

Q Sure. In other words, like you take for example a baby who falls from a bed. Doctors and mothers don't get especially exercised (sic) about that because there is not going to be a great deal of damage to the child, generally speaking. Isn't that right?

A Yes, usually.

Q One of the reasons for that is because of the weight of the child, is it not?

A Yes. The weight and the fact that bones are softer and they kind of bounce with the blow.

Q Yes. And isn't it true then that—you take a man on a football field; let's say a fullback. They like to have kind of a heavier man back there hitting the line, don't they?

A I suppose.

Q Sure. And there's a reason for that, isn't there, insofar as hitting the line is concerned?

A I really don't know.

Q Okay. But at least a heavier man can hit the line harder than a man who is not very heavy. Isn't that right?

A Yes.

(Tr-77)

Q Okay. And so isn't it true that with regard to an impact, you must consider at least weight? Isn't that important?

A The weight?

Q Let's take this —

A Are you referring to the weight of the person involved?

Q No. I don't even necessarily confine it to persons. Let's take, for example, an automobile. Take a little car, a little Pinto, let's say, going ten miles an hour and hitting a brick wall. Would that not have a different impact force than a great big Cadillac going the same distance at the same speed and hitting the wall?

A Certainly.

Q And the reason for that is the weight. Isn't that correct?

A Yes.

Q And so you have a circumstance where you have weight. We'll call that W. And then the speed. We'll put a V up there and call that velocity. Isn't that right? Now, we have weight and velocity. When you put weight and velocity together in some way way, this will equal the force of an impact. Is that correct?

A Yes.

Q Now, you take a situation where — assume, for example, that the velocity in a given situation is the same, no matter what it is.

A Um-hmmm.

(Tr-78)

Q In order to increase — the velocity would be the same. And let's say the weight is the same.

A Um-hmm.

Q Well, in order to vary the impact, you would have to — well, it wouldn't vary at all, would it?

A That's right.

Q So in order to increase the force of an impact, you would have to increase one of these two things, isn't that right?

A Yes.

Q Now, insofar as Mr. Vella is concerned — and I ask you if, in your physical examination, you weighed him?

A No.

Q Okay. But whatever his weight, he looks like — well, he is kind of chubby. And I don't know what he weighs, but I would say maybe 185 pounds. Would you guess him to be something like that?

A Yes, approximately.

Q If he weighed that at the time of the trauma and if he — you don't know the circumstances of his hitting his head at all, do you?

A No.

Q All right. But in the event that no matter what he weighed, between 150 or 200 pounds or anywhere in there, if he increased his weight by at least 100 pounds, this would have a significant effect upon the trauma of the head now,

(Tr-79)

wouldn't it?

A No, not necessarily at all. Depending on the circumstances —

Q If he hit his head without increasing the weight, that would produce one force or impact. Isn't that correct?

A Um-hmm.

Q And didn't you say that in order to increase the impact, if the velocity doesn't increase, you would have to increase the weight. Isn't that right?

A Um-hmm.

Q So by an increase of weight by some pounds, 100 pounds or so, and coming down and hitting his head on an instrument, this would produce a greater force than if he didn't have the increased weight.

A Referring to the specific incidents of Mr. Vella's fall by this discussion?

Q Well, a similar circumstance.

A Well, the man's weight may or may not have any bearing on this, depending on if the weight was behind the fall. You could conceivably slip sideways and hit your head and your overall weight may not have anything to do with it.

Q This is important. In other words, you would have to know these facts in order to make a determination as to what kind of trauma, to what degree of force the head was traumatized. Isn't that right?

(Tr-80)

A Yes.

Q And people can be rendered unconscious by a mere hitting on the head with some kind of instrument. Isn't that right?

A Oh, yes.

Q Now, insofar as the cause of the dizziness that you mentioned, the causes of—this was in response to Mr. Mundell's question. You said that there are causes of dizziness and you enumerated. Was that dizziness it causes?

A Yes.

Q And you said there is this inner ear complex, the labyrinthine disorder?

A Yes.

Q The pseudo-Meniere's Disease and the like.

A Yes.

Q And so far as the virus is concerned, you said there were flu and respiratory difficulties. Did you, in Mr. Vella, find any difficulty with regard to virus, flu or respiratory problems?

A Well, no. Actually, the thing is this: If these things did happen at that time, there would be no evidence of it now and there would certainly be no way to make a diagnosis.

Q I don't understand. You found, when you examined him, that he does have a vestibular problem?

(Tr-81)

A Yes, right.

Q All right. And you found that he has a vestibular problem and that he indicated he suffered dizziness?

A Yes.

Q All right. So at the time of your examination, you did

not find any virus or flu or respiratory problem?

A See, when I mentioned those kinds, this is kind of a complete list. If any of these things did happen or existed or is responsible for Mr. Vella's problem that would have been something that happened at that time. I was just going through a list of the possible things that could cause a labyrinthine disorder with diziness. Essentially, we have no definite, concrete diagnosis here. The only thing we have—

Q You keep saying that. Yet you have told us—you have diagnosed many things. We'll go into that. All I'm asking you is: You have given a list of possible causes; I'm trying to find out what that is. Possible causes of what?

A Possible causes of dizziness, with or without evidence of labyrinthine disease.

Q Sticking right here to Mr. Vella, you found—again we keep going over this, but you did finally find a vestibular labyrinthine disorder. Isn't that correct?

A Right.

(Tr-82)

Q Did you find a virus problem here at the time of your examination?

A Well, of course, no, of course not.

Q Did you find he was using drugs of an antibiotic nature?

A Well, I have no idea what drugs—

Q Did you find that he was?

A No.

Q Did you find that he had a metabolic disorder hardening of the arteries?

A That wasn't investigated.

Q But did you find it?

A No.

Q All right. You didn't find that. And you didn't find the drugs. Did you find an inner ear disorder?

A Yes.

Q All right. And so you are saying that based on your findings, certainly, that you would have to conclude, would you not, that just if you stick to your findings— and you had all the opportunity to examine him—sticking to your findings, you would have to conclude that his dizziness is based on an inner ear problem?

A No, you can't say that, either. The only thing we can say with any certainty is—first of all, let me go back. The only positive finding we have is a decreased labyrinthine response which has fluctuated. You cannot definitely

(Tr-83)

correlate that with the patient's symptoms necessarily. In other words, this is not a diagnosis. This is not a disease entity. This just shows there is some damage to the vestibular mechanism, the cause of which is not evidenced by this test. That's as far as you can go on the basis of the findings of that test: He has a vestibular disorder, yes; the cause of it is uncertain. Definitely, there is no way we can pinpoint an ideology or cause on the basis of this test.

Q You have already agreed that the cause is organic.

A Yes.

Q And you said there are a multitude of things. And didn't you say you could go on all day, saying what might have caused it, what might cause dizziness?

A Yes, the list is —

Q But weren't you put on notice, since he has a vestibular problem, an inner ear problem, and since you have already testified that dizziness is consistent with an inner ear vestibular problem —

A Yes.

Q — that in all probability, with the history of the problem, that the vestibular problem and the dizziness resulting and fear of falling is all connected with the trauma, all connected with the 1968 incident?

A I can't say that.

(Tr-84)

Q You mean you won't say that.

A I can't.

Q Do you have a reason not to say it?

A As far as we can determine, we have no way to determine the cause of this vestibular function on an ENG. There is absolutely no possible way.

Q But there is one thing for sure; that trauma is certainly one of the causes for a vestibular problem such as what Mr. Vella has.

A Severe head trauma can do this, yes.

Q All right. Were you apprised of the fact that the patient never ever had any history of diabetes?

A That's right.

Q Were you apprised of that fact?

A Yes.

Q Were you apprised of the fact that he had absolutely no medical difficulty of any kind whatsoever prior to the trauma of 1968?

MR. BALLARD: That's not true.

MR. MUNDELL: If the Court please, that is not true. It's in the record that he has had problems before.

MR. JAQUES: Just a moment. The record here is by the defendant's own witness and it is that he had a clean bill of health.

(Tr-85)

THE COURT: But that doesn't mean he had a problem before he got a clean bill of health. I may have had a

cold, but then I get cured from it. It doesn't mean I didn't have a cold.

MR. JAQUES: Please, your Honor. I'll clear this up.

THE COURT: All right, but there is an objection.

MR. JAQUES: It's an invalid objection.

THE COURT: Wait a minute. I am asked to rule on it.

MR. JAQUES: Well, go ahead.

THE COURT: If you can clear it up all right. If not, I'm going to sustain the objection and strike the testimony.

MR. JAQUES: Well, with that, I will attempt to proceed.

THE COURT: Let the record show that the Court is not threatened. And I will advise you not to make those comments.

MR. JAQUES: I move for a mistrial.

THE COURT: It is denied.

Q (By Mr. Jaques) Now, Doctor, we have testimony here by the defendant's own Ford physician that in 1967 there was nothing medically wrong with the plaintiff, that he was fit for duty, that he was given some kind of an A

(Tr-86)

rating medically insofar as the result of his medical examination is concerned. And to use his words—and I repeat—"well, I would say he was given a clean bill of health in 1967." We further have testimony to the effect that the plaintiff had indicated—

COURT REPORTER: Excuse me. I am going to have to put more paper in my machine.

THE COURT: The doctor just asked if he could call his office. I don't know how long we'll be going. We're past the time. Let's take a short recess and the doctor can call his office.

(Brief recess.)

(Jury present.)

MR. JAQUES: Rather than to continue on that same question, perhaps we can bring out what is required here.

Q (By Mr. Jaques): Doctor, testimony has shown that over the years since 1949 until 1968, the plaintiff had worked for the Ford Motor Company off and on and intermittently with the plant and also on the ships. And it is shown that he was medically examined by the Ford Motor Company on an annual basis and that he was rendered fit for duty with some kind of an A classification. I can't remember exactly what it was. A something. And I take it that would

(Tr-87)

be a rather high classification because the doctor said that in 1967, based on that physical examination, that Mr. Vella had a clean bill of health.

And take a circumstance where there is no history whatsoever of any organic disease like metabolic diseases, hardening of the arteries, any thyroid problems, no history of any impaired circulation of the brain, where there is no history of any drug reaction of an antibiotic nature, where there is no history of a prolonged virus or respiratory problem and where there is no history of any kind of disability organically of that nature and that further, there is no indication of the medical records of the Ford Clinic—well, of Ford—that the patient—well, the plaintiff here—had any problems medically from the time that he had his physical examination until he sustained his injury in 1968 and that the plaintiff himself testified that he was enjoying good health at the time of the trauma in 1968.

With those facts in mind, Doctor, and moreover, with no medical evidence to the effect that there has been any of those problems since the 1968—that is to say, diabetes and all these other things—and with the history of a trauma and with the finding that you did make with regard to the vestibular difficulty, is it more likely than not that since this vestibular difficulty certainly can be caused from trauma—

(Tr-88)

well, more likely than not that in the case of Mr. Vella it was caused from trauma?

A Well, if I could just elaborate on that a little bit, first of all—

Q I'll just ask you if you can answer the qusetion as it is posed?

A No, not yes or no. I think that would need a little qualification.

Q All right.

A First of all, I know for a fact that most of these factory physicals are fairly cursory and they are not complete physical examinations down to the point where they test for thyroid function, et cetera, et cetera. These are examinations where the heart and lungs are listened to, routine blood tests are done and blood pressure is taken—

Q I have to say this, Doctor: Rather than going into that, you have to take as fact what I have just given you with regard to the hypothetical, which would be identical to the circumstances of Mr. Vella. In other words, we have to accept the integrity of the examining physician when he says that he has given a clean bill of health and that he is of A-1 condition and that he has nothing wrong with him medically. And so with that given factual circumstance and with the further circumstances that there never was in

(Tr-89)

nineteen years any showing of these diseases like we were talking about and disabilities organically like we were talking about, then with that in mind, I wonder if you could answer the question: Is it not more likely than not that the vestibular difficulty resulted from the trauma—

MR. MUNDELL: Your Honor, if the Court please, I will have to object to that question because in the past 19 years, there have been symptoms of dizziness and fatiguibility and loss of balance.

THE COURT: Well, he started his question with that.

MR. MUNDELL: But the last part of the question was that he hasn't had any of these things in the last 19 years, which isn't true.

MR. JAQUES: No, I didn't say that.

THE COURT: I didn't understand that. I'll overrule the objection.

MR. JAQUES: I didn't say that.

THE WITNESS: Again, I think a little qualification is in order here. One of the causes of vestibular damage and that I mentioned as one of the very, very common causes, is a thyroid problem. Now, a thyroid problem itself, whether it be hypothyroid — that is, a person on the low thyroid side — or hyperthyroid — on the high thyroid side — very often, these people are asymptomatic. They feel quite

(Tr-90)

healthy.

Q (By Mr. Jaques) I don't ask you to go into the realm of speculation. In other words, whether or not there's gold in some vein, I don't ask for that because I simply ask you to take a circumstance where there is no evidence of any thyroid problem and where there is in fact evidence

that the patient, the plaintiff here — I know you're used to referring to them as patients and that's why I say that — that the plaintiff had no difficulty at all with regard to these matters. Now, given those circumstances, where there is neither a finding of any of these diseases or any symptomatic complaint of these diseases but there is a showing, over the years, of trauma — that is to say, head trauma, hitting of the head over the years, and with the trauma being in 1968, is it not more likely than not that the vestibular problem would be the result of a trauma?

A I would say very possibly not. On this basis, it's hard for me to conceive that a patient could sustain a labyrinthine disfunction on the basis of trauma and yet be able to perform his duties immediately after this happened. I just can't justify this.

All right. When you say it's hard for you to conceive this, now, I think you went into this before, at the time of your deposition. But you did admit then that it is

(Tr-91)

entirely possible that this could have happened. Do you remember saying that?

A That what could have happened specifically?

Q That the vestibular problem could have resulted and that he still could have gone on for a limited period of time doing his work.

MR. BALLARD: Where are you referring to?

THE WITNESS: I think in the deposition I mentioned this is highly improbable. That it is possible but highly improbable.

Q (By Mr. Jaques, continuing): But you said at least it is possible, didn't you?

A That's correct.

Q All right. You have already indicated that the vestibular problem would have to be with regard — you have already indicated it's organic. You have said that already, haven't you?

A It's most likely —

Q But you have ruled out these other factors where indeed he doesn't have any of these other diseases that could cause dizziness and the onset of dizziness and that there had been a repeated number of head trauma over the years. Well, let's go into that. You know, where one has a history of being hit on the head and having had trauma, you know, like over the years, this can subside, isn't that true?

(Tr-92)

A What can subside? The dizziness resulting from the injuries?

Q Yes.

A Oh, yes.

Q Okay. But then it's like, well, several hits and then finally there can be that straw that breaks the camel's back, isn't that true? In other words, there can be that final trauma which does cause a vestibular difficulty. Isn't that right?

A The injury would have had to have been quite severe in order to have done this.

Q Doctor, please. Just answer the question. If you have a history of repeated conks on the head, repeated head trauma, and then finally there is a history of a head trauma causing unconsciousness, is it not a fact that the person thus becomes more susceptible to a vestibular kind of disorder because of the repeated trauma on the head?

A I don't think so.

Q You don't think so?

A No. I don't think little bumps on the head have a cumulative effect, as far as destroying—damage of the vestibular mechanism.

Q Why did you call them little bumps on the head?

A Well, bumps on the head.

(Tr-93)

Q Why did you call them little bumps on the head?

A I really don't know. Let's just refer to them as bumps on the head.

Q Do you have any reason for calling them little bumps on the head?

A No.

Q So therefore you don't mean to characterize to this jury those bumps on the head as being small, do you?

A Well, generally speaking, a bump, if it leaves some swelling, if a patient is unconscious or hospitalized, this sort of thing—when you were describing this to me, you were mentioning the patient had many, many bumps along the way. So that's the reason I referred to them as little bumps.

Q There is a history of his having several bumps on the head of various kinds brought into this record and those repeated bumps—and Doctor, you may say anything you want because I realize you are under oath and you understand your oath. But I just want you to make a statement with regard to continued trauma on the head— is it not a fact, medically speaking, that one becomes more susceptible to that ultimate vestibular difficulty when he does receive a trauma on the head of the nature causing unconsciousness to be rendered?

A Well, I really don't think so. But this is—we're

(Tr-94)

getting into an area that's a little out of my field—

Q You have answered my question. That's fine. You don't think so.

A That's right.

Q That's okay. And so I take it then it would follow that you are saying bumps on the head or trauma to the head previously, where it had been shown that he had had bumps on the head and that he had had dizziness and had suffered these symptoms resulting from the bumps on the head—that those would have absolutely no significance whatsoever in relation to a subsequent final bump or trauma to the head rendering unconsciousness?

A Well, actually I think if these bumps were fairly severe, I think there is a good possibility that there might be a cumulative effect. I don't know what you are talking about when you say bumps. It could be a tap on the head or severe enough to render unconscious. What does a bump mean? What are you referring to when you say bump?

Q All right. Specifically, we had a circumstance where there was a hitting of the head on, I think, a drill; a drill in a factory.

A That was in 1957. Is that the one that you are referring to? I think on the work record here in the clinic record at Ford, he apparently struck his head in 1957. After he had an episode of dizziness.

(Tr-95)

Q Well, let's see. There was one in 1956.

A Yes.

Q There was trauma to the head on something that looked like a drill.

A Yes.

Q That was in 1956.

A Right.

Q Then there was 1966. I think that there was trauma to the head caused from hitting an exhaust pipe on the main engine and that there was a contusion to one of the lobes, the frontal lobe, and in 1956 this was a temporal lobe area. And I think there's another one here. Well, I have to go by memory here at this time, but based on the public health records, there was a—I think—and in 1958—so let's see if we can get it in chronological order. 1956, 1958 and 1966. Now, the one in 1958, had you heard about this one before?

A No.

Q That wouldn't be in those Ford records. That would be at the Public Health. That he had bumped the top of his head in the occipital area. So you've got the temporal and the occipital and the parietal regions of the head where there had been trauma. And then the one—let's see. And I think there was one—at least those: 1956, 1958, 1966 and 1968.

(Tr-96)

So you had those traumas and the final trauma was in 1968. And then, based on these facts, based on your testimony, would you say that these have absolutely nothing to do, no relationship in any way with any ultimate vestibular problem or susceptibility to vestibular problem from a trauma that ultimately happened like in this instance in 1968?

A Well, I'll tell you again that it's very difficult to determine the severity of these injuries really. All I can say is that it's impossible for me to determine whether or not thse head injuries would make him any more sus-

ceptible to the alleged injury in 1968. There is no way I could know this.

Q So you are saying you would have to have some more facts. Is that right?

A I'm not even too sure that would clarify everything here. I think possibly—

Q Can you say that even if you had the facts and even if the magnitude of severity were shown to you, you still wouldn't be able to say that the repeated number of head traumas would thus render one susceptible to vestibular difficulty with the ultimate trauma that resulted?

A I would answer that by saying repeated severe injuries might certainly have some bearing.

Q They might?

(Tr-97)

A Yes.

Q And that's about as far as you want to go in answering that question, is that right?

A Yes.

Q Okay. That's all right. And I think then that you want to say, do you not, Doctor—leave with this note—that you just don't know and you just cannot say and you just cannot or will not say, based on your expertise and based on your background and based on your knowledge and based on the facts presented to you and based on your examination and based on all the tests that you had and the opportunities for testing that you had with the plaintiff, that you just simply will not or cannot say, with a reasonable degree of medical certainty, the probable causation of the vestibular difficulty.

MR. MUNDELL: If the Court please, this question has been asked and asked and asked and the doctor has

answered it the best he can.

MR. JAQUES: This is cross-examination and it has not been asked in this manner.

THE COURT: Well, I will take the answer. But I would like to say I do believe that it has been asked and asked, but not in this manner. I will agree with you.

THE WITNESS: Shall I answer?

(Tr-98)

Q (By Mr. Jaques) Would you like the question read back to you?

A No, that's fine. Again, from all the information I have, the tests we have done—

Q Just answer the question, if you will.

A I cannot, with any degree of certainty, state why Mr. Vella is having these episodes of dizziness on the evidence that I have.

MR. JAQUES: All right, Doctor. Thank you very much.

MR. MUNDELL: That's all, your Honor.

Thank you, Doctor.

THE COURT: All right, Doctor, thank you.

I believe the Doctor can be excused, can he not?

MR. JAQUES: Surely.

MR. MUNDELL: Yes, your Honor.

(Witness excused.)

MULTILATERAL—SHIPOWNERS' LIABILITY
OCT. 24, 1936
October 24, 1936 [T.S. No. 951]

Convention between the United States of America and other members of the International Labor Organization respecting shipowners' liability in case of sickness, injury, or death of seamen. Adopted by the General Conference of the International Labor Organization, twenty-first session, Geneva, October 24, 1936; ratification advised by the Senate of the United States, subject to understandings; June 13, 1938; ratified by the President of the United States, subject to the said understandings, August 15, 1938; ratification of the United States of America registered with the Secretary-General of the League of Nations October 29, 1938; proclaimed by the President of the United States September 29, 1939.

BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

A PROCLAMATION

Shipowners' Liability (Sick and Injured Seamen) Convention 1936. Preamble

WHEREAS a draft convention (No. 55) with regard to the liability of the shipowner in case of sickness, injury, or death of seamen, was adopted on the twenty-fourth day of October nineteen hundred and thirty-six, by the General Conference of the International Labor Organization at its twenty-first session held at Geneva October 6-24, 1936, a certified copy of which draft convention, communicated by the Secretary-General of the League of Nations, acting in conformity with the requirements in the nineteenth Article of the Constitution of the International Labor Organization, to the Government of the United States of America

as a Member of said Organization, is, in the French and English languages, word for word as follows:

General Conference, International Labor Organization.

The General Conference of the International Labour Organisation,

Having been convened at Geneva by the Governing Body of the International Labour Office, and having met in its Twenty-first Session on 6 October 1936, and

Having decided upon the adoption of certain proposals with regard to the liability of the shipowner in case of sickness, injury or death of seamen, which is included in the second item on the Agenda of the Session, and

Having determined that these proposals shall take the form of a Draft International Convention,

Adoption of Draft Convention.

adopts this twenty-fourth day of October of the year one thousand nine hundred and thirty-six, the following Draft Convention which may be cited as the Shipowners' Liability (Sick and Injured Seamen) Convention, 1936:

ARTICLE 1.

Application.

1. This Convention applies to all persons employed on board any vessel, other than a ship of war, registered in a territory for which this Convention is in force and ordinarily engaged in maritime navigation.

Exceptions by national law or regulation permitted.

2. Provided that any Member of the International Labour Organisation may in its national laws or regulations make such exceptions as it deems necessary in respect of—

(a) persons employed on board,
  (i) vessels of public authorities when such vessels are not engaged in trade;
  (ii) coastwise fishing boats;
  (iii) boats of less than twenty-five tons gross tonnage;
  (iv) wooden ships of primitive build such as dhows and junks;
(b) persons employed on board by an employer other than the shipowner;
(c) persons employed solely in ports in repairing, cleaning, or unloading vessels;
(d) members of the shipowner's family;
(e) pilots.

ARTICLE 2.

Liability of shipowner.

1. The shipowner shall be liable in respect of—

Sickness and injury during term of employment.

(a) sickness and injury occuring between the date specified in the articles of agreement for reporting for duty and the termination of the engagement;

Resultant death.

(b) death resulting from such sickness or injury.

Exceptions by national law or regulation permitted.

2. Provided that national laws or regulations may make exceptions in respect of:

(a) injury incurred otherwise than in the service of the ship;
(b) injury or sickness due to the wilful act, default or misbehaviour of the sick, injured or deceased person;
(c) sickness or infirmity intentionally concealed when engagement is entered into.

Refusal to be medically examined.

3. National laws or regulations may provide that the shipowner shall not be liable in respect of sickness, or death directly attributable to sickness, if at the time of the engagement the person employed refused to be medically examined.

ARTICLE 3.

Medical care and maintenance, scope.

For the purpose of this Convention, medical care and maintenance at the expense of the shipowner comprises:

(a) medical treatment and the supply of proper and sufficient medicines and therapeutical appliances; and
(b) board and lodging.

ARTICLE 4.

Period of liability.

1. The shipowner shall be liable to defray the expense of medical care and maintenance until the sick or injured person has been cured, or until the sickness or incapacity has been declared of a permanent character.

Limitation permitted.

2. Provided that national laws or regulations may limit the liability of the shipowner to defray the expense of medical care and maintenance to a period which shall not be less than sixteen weeks from the day of the injury or the commencement of the sickness.

Provisions where compulsory sickness insurance, etc., is in force.

3. Provided also that, if there is in force in the territory in which the vessel is registered a scheme applying to seamen of compulsory sickness insurance, compulsory accident insurance or workmen's compensation for accidents, national laws or regulations may provide—

(a) that a shipowner shall cease to be liable in respect of a sick or injured person from the time at which that person becomes entitled to medical benefits under the insurance or compensation scheme;

(b) that the shipowner shall cease to be liable from the time prescribed by law for the grant of medical benefits under the insurance or compensation scheme to the beneficiaries of such schemes, even when the sick or injured person is not coverd by the scheme in question, unless he is excluded from the scheme by reason of any restriction which affects particularly foreign workers or workers not resident in the territory which the vessel is registered.

ARTICLE 5.

Incapacity for work.

1. Where the sickness or injury results in incapacity for work the shipowner shall be liable—

(a) to pay full wages as long as the sick or injured person remains on board;

(b) if the sick or injured person has dependents, to pay wages in whole or in part as prescribed by national laws or regulations from the time when he is landed until he has been cured or the sickness or incapacity has been declared of a permanent character.

Limitation permitted.

2. Provided that national laws or regulations may limit

the liability of the shipowner to pay wages in whole or in part in respect of a person no longer on board to a period which shall not be less than sixteen weeks from the day of the injury or the commencement of the sickness.

Provisions where compulsory sickness insurance, etc., is in force.

3. Provided also that, if there is in force in the territory in which the vessel is registered a scheme applying to compulsory sickness insurance, compulsory accident insurance or workmen's compensation for accidents, national laws or regulations may provide:

(a) that a shipowner shall cease to be liable in respect of a sick or injured person from the time at which that person becomes entitled to cash benefits under the insurance or compensation scheme;

(b) that the shipowner shall cease to be liable from the time prescribed by law for the grant of cash benefits under the insurance or compensation scheme to the beneficiaries of such schemes, even when the sick or injured person is not covered by the scheme in question, unless he is excluded from the scheme by reason of any restriction which affects particularly foreign workers or workers not resident in the territory in which the vessel is registered.

ARTICLE 6.

Expense of repatriation.

1. The shipowner shall be liable to defray the expense of repatriating every sick or injured person who is landed during the voyage in consequence of sickness or injury.

Port to which return is effected.

2. The port to which the sick or injured person is to be returned shall be—

(a) the port at which he was engaged; or

(b) the port at which the voyage commenced; or

(c) a port in his own country or the country to which he belongs; or

(d) another port agreed upon by him and the master or shipowner, with the approval of the competent authority.

Charges included in expense of repatriation.

3. The expense of repatriation shall include all charges for the transportation, accommodation and food of the sick or injured person during the journey and his maintenance up to the time fixed for this departure.

Person capable of work.

4. If the sick or injured person is capable of work, the shipowner may discharge his liability to repatriate him by providing him with suitable employment on board a vessel proceeding to one of the destinations mentioned in paragraph 2 of this Article.

ARTICLE 7.

Burial expenses.

1. The shipowner shall be liable to defray burial expenses in case of death occurring on board, or in case of death occurring on shore if at the time of his death the deceased person was entitled to medical care and maintenance at the shipowner's expense.

Reimbursement by insurance institution.

2. National laws or regulations may provide that burial expenses paid by the shipowner shall be reimbursed by an insurance institution in cases in which funeral benefit is payable in respect of the deceased person under laws or regulations relating to social insurance or workmen's compensation.

ARTICLE 8.

Safeguarding of personal property.

National laws or regulations shall require the shipowner or his representatitive to take measures for safeguarding property left on board by sick, injured or deceased persons to whom this Convention applies.

ARTICLE 9.

Settlement of disputes.

National laws or regulations shall make provision for securing the rapid and inexpensive settlement of disputes concerning the liability of the shipowner under this Convention.

ARTICLE 10.

Exemption from certain liability.

The shipowner may be exempted from liability under Articles 4, 6 and 7 of this Convention in so far as such liability is assumed by the public authorities.

ARTICLE 11.

Equality of treatment.

This Convention and national laws or regulations re-

lating to benefits under this Convention shall be so interpreted and enforced as to ensure equality of treatment to all seamen irrespective of nationality, domicile or race.

ARTICLE 12.

More favorable agreements, etc., not affected.

Nothing in this Convention shall affect any law, award, custom or agreement between shipowners and seamen which ensures more favourable conditions than those provided by this Convention.

ARTICLE 13.

Declarations respecting certain territories.

1. In respect of the territories referred to in Article 35 of the Constitution of the International Labour Organisation, each Member of the Organisation which ratifies this Convention shall append to its ratification a declaration stating:

(a) the territories in respect of which it understakes to apply the provisions of the Convention without modification;

(b) the territories in respect of which it undertakes to apply the provisions of the Convention subject to modifications, together with details of the said modifications;

(c) the territories in respect of which the Convention is inapplicable and in such cases the grounds on which it is inapplicable;

(d) the territories in respect of which it reserves its decision.

Declarations to be integral parts of ratifications.

2. The undertakings referred to in sub-paragraphs (a) and (b) of paragraph 1 of this Article shall be deemed to be an integral part of the ratification and shall have the force of ratification.

Subsequent cancelation of reservations.

3. Any Member may by a subsequent declaration cancel in whole or in part any reservations made in its original declaration in virtue of sub-paragraphs (b), (c) or (d) of paragraph 1 of this Article.

ARTICLE 14.

Ratifications, registration.

The formal ratifications of this Convention shall be communicated to the Secretary-General of the League of Nations for registration.

ARTICLE 15.

Scope.

1. This Convention shall be binding only upon those Members of the International Labour Organisation whose ratifications have been registered with the Secretary-General.

Effective date.

2. It shall come into force twelve months after the date on which the ratifications of two Members have been registered with the Secretary-General.

3. Thereafter, this Convention shall come into force for any Member twelve months after the date on which its ratification has been registered.

ARTICLE 16.

Notification to Members.

As soon as the ratifications of two Members of the International Labour Organisation have been registered, the Secretary-General of the League of Nations shall so notify all the Member of the International Labour Organisation. He shall likewise notify them of the registration of ratifications which may be communicated subsequently by other Members of the Organisation.

ARTICLE 17.

Denunciation.

1. A Member which has ratified this Convention may denounce it after the expiration of ten years from the date on which the Convention first comes into force, by an act communicated to the Secretary-General of the League of Nations for registration. Such denunciation shall not take effect until one year after the date on which it is registered.

Extensions.

2. Each Member which has ratified this Convention and which does not, within the year following the expiration of the period of ten years mentioned in the preceding paragraph, exercise the right of denunciation provided for in this Article, will be bound for another period of ten years and, thereafter, may denounce this Convention at the expiration of each period of ten years under the terms provided for in this Article.

ARTICLE 18.

Reports at 10-year intervals.

At the expiration of each period of ten years after the

coming into force of this Convention, the Governing Body of the International Labour Office shall present to the General Conference a report on the working of this Convention and shall consider the desirability of placing on the Agenda of the Conference of the question of its revision in whole or in part.

ARTICLE 19.

Revision of Convention, effect.

1. Should the Conference adopt a new Convention revising this Convention in whole or in part, then, unless the new Convention otherwise provides,

(a) the ratification by a Member of the new revising Convention shall *ipso jure* involve the immediate denunciation of this Convention, notwithstanding the provisions of Article 17 above, if and when the new revising Convention shall have come into force;

(b) as from the date when the new revising Convention comes into force this Convention shall cease to be open to ratification by the Members.

2. This Convention shall in any case remain in force in its actual form and content for those Members which have ratified it but have not ratified the revising Convention.

ARTICLE 20.

Texts, authenticity.

The French and English texts of this Convention shall both be authentic.

AND WHEREAS: it is provided in Article 14 of the said draft convention that the formal ratification thereof shall

be communicated to the Secretary-General of the League of Nations for registration and in Article 15 that the convention shall come into force twelve months after the date on which the ratifications of two Members of the International Labor Organization have been registered with the Secretary-General of the League of Nations and that thereafter the convention shall come into force for any Member twelve months after the date on which its ratification has been registered;

U.S. ratification subject to understandings.

AND WHEREAS the said draft convention was duly ratified on the part of the United States of America subject to understandings as follows:

> "That the United States Government understands and construes the whole 'vessels registered in a territory' appearing in this convention to include all vessels of the United States as defined under the laws of the United States.
>
> "That the United States Government understands and construes the words 'maritime navigation' appearing in this Convention to mean navigation on the high seas only.
>
> "That the provisions of this convention shall apply to all territory over which the United States exercises jurisdiction except the Government of the Commonwealth of the Philippine Islands and the Panama Canal Zone, with respect to which this Government reserves its decision."

Ratification by Belguim, registration.
Ratification by U.S., registration.

AND WHEREAS the ratification of the said draft convention by Belgium was registered with the Secretary-General of the League of Nations on April 11, 1938, subject to subsequent decisions regarding application to the Belgian Congo and the territories under Belgian Mandate and the ratification thereof by the United States of America, subject to the understandings above recited, was registered with the Secretary-General on October 29, 1938;

Effective date; scope.

AND WHEREAS by such registrations the said draft convention became a formal convention between the United State of America and Belgium on October 29, 1938, which, pursuant to Article 15 thereof, will come into force as between the United States of America and Belgium on October 29, 1939, twelve months after the date on which the ratification of the United States of America was registered with the Secretary-General of the League of Nations, and pursuant to the same Article, will come into force, for other Members of the International Labor Organization whose ratifications may have been or hereafter may be registered with the Secretary-General of the League of Nations subsequent to October 29, 1938, twelve months after the date on which the ratification has been or may be registered in each case;

Proclamation.

NOW, THEREFORE, be it known that I, Franklin D. Roosevelt, President of the United States of America, have caused the said convention to be made public to the end that the same and every article and clause thereof may be observed and fulfilled in good faith by the United States of America and the citizens thereof, on and from October 29, 1939, subject to the understandings above recited and to any exception and any limitations of liability in ac-

cordance with the provisions of the convention which may be made by legislation or regulations on the part of the United States of America.

IN TESTIMONY WHEREOF I have hereunto set my hand and caused the Seal of the United States of America to be affixed.

DONE at the city of Washington this twenty-ninth day of September in the year of our Lord one thousand nine hundred and thirty-nine and of the Independence of the United States of America the one hundred and sixty-fourth.

[SEAL]

FRANKLIN D. ROOSEVELT

By the President:

CORDELL HULL

Secretary of State: